

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0728

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>		STREET ADDRESS (If rural, give location) <u>603 Stonelagh Road</u>	
3. NAME OF DECEASED (Type or Print) <u>ALMA</u> (First) <u>E.</u> (Middle) <u>ABBOTT</u> (Last)		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 5-1871</u>
9. AGE last birthday <u>79</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Bates</u>		14. MOTHER'S MAIDEN NAME <u>John-Anna Griffith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Wm. Christopher 603 Stonelagh Rd</u> (daughter)			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Chronic Myocarditis</u>		<u>2 1/2 years</u>
Antecedent cause(s)	(b) <u>Chronic Endocarditis</u>		<u>2 1/2 "</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Arterio sclerosis</u>		<u>Several years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Manic Depressive Psychosis</u>	<u>3 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5-16-, 1949, to 1-17-, 1951, that I last saw the deceased alive on 1-17-, 1951, and that death occurred at 7:32 P.m., from the causes and on the date stated above.

SIGNATURE James P. Sands, M.D. (Degree or title) Laurel Sanitarium Laurel, Md. ADDRESS DATE SIGNED 1-17-1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan. 20, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>1/19/51</u>	REGISTRAR'S SIGNATURE <u>W. C. Hedrick</u>	24. FUNERAL DIRECTOR <u>W. C. Hedrick</u>	ADDRESS <u>4510 Liberty Heights Ave.</u>

DM

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 072343

1. PLACE OF DEATH. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>3004- 30'th St., S.E.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GRACE</u> <u>WATERS</u> <u>ADAMSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN.</u> <u>22</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 2 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>43</u> yrs.
11. FATHER'S NAME <u>Richard T. Waters</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Grace Beard</u>		14. INFORMANT AND ADDRESS <u>Decedent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>579-22-0244</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

2 yrs. 4 mo.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov. 9, 1950, to JAN. 22, 1951, that I last saw the deceased alive on JAN. 22, 1951, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Leo PinecaneM.D.,Glenn Dale SanatoriumGlenn Dale, Maryland1/22/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/22/51</u>	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG. <u>1/22/51</u>	REGISTRAR'S SIGNATURE <u>W. W. Weiss</u>	24. FUNERAL DIRECTOR <u>J. W. Lee's Sons Co.</u>	ADDRESS <u>300-4th St. N.E. Washington 2, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0730

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> TOWN <u>Chesley</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges General Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> TOWN <u>Chesley</u> STREET ADDRESS <u>6014 - State Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Nicholas</u> (First) <u>Antica</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>January 13</u> (Month) <u>13</u> (Day) <u>1957</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 22, 1898</u>
9. AGE last birthday <u>52</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement finisher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>unknown</u>	14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Hospital Record Chesley Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Pulmonary embolism</u>	
Antecedent cause(s)	(b) <u>Lobar pneumonia</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Toxemia</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) John W. Maloney M.D. Dep. Med. Exam. Chesley - Md. DATE SIGNED 1-13-51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan 17, 1951 NAME OF CEMETERY OR CREMATORY Mt. Hope LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. 1/16/51 REGISTRAR'S SIGNATURE Amanda Downey 24. FUNERAL DIRECTOR F. Pasche Sons Hyattsville Md. ADDRESS 511 916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for addition in #18 shown on: MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0731 231

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md Prince Georges COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Decatur Heights Md.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Decatur Heights Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS 5103 Annapolis Road (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Emma (Middle) Miles (Last) Beattie	4. DATE OF DEATH	(Month) Jan 11, 1951 (Year) 19
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 10/29/1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	9. AGE last birthday 82 years
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gilbert Outcalt		14. MOTHER'S MAIDEN NAME Elizabeth Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS W. R. Beattie Decatur Heights Md.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Heart failure		24 hours
Antecedent cause(s) (b) Hypertensive Pneumonia		one week
Underlying cause: absolute bed confinement) (1-19-51 - ans)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemiplegia left		6 years
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 27, 1950, to Jan 11, 1951, that I last saw the deceased alive on Jan 9, 1951, and that death occurred at 6:45 A. M., from the causes and on the date stated above.

SIGNATURE: *Hugh H. Dwyer, M.D.* ADDRESS: 1833 Monroe St NE Washington DC DATE SIGNED: *[Signature]*

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan 13, 1951	NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	LOCATION (City, town, or county) Colmar Manor Md.	(State)
DATE REC'D BY LOCAL REG. Jan 11/1951	REGISTRAR'S SIGNATURE <i>Amanda H. Dwyer</i>	24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Maryland.		

MARGIN RESERVED FOR BINDING

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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

RECEIVED
JUN 15 1951
U. S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0732 *2/5*
 Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Pr. Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) Hyattsville		CITY (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
TOWN Hyattsville		TOWN Hyattsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8114 14th Avenue		STREET ADDRESS (If rural, give location) 8114 14th Ave.	
3. NAME OF DECEASED (First) Robert (Middle) Green (Last) Bennett		4. DATE OF DEATH (Month) Jan. (Day) 26 (Year) 1951	
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1-14-1899
9. AGE last birthday 52 yrs.		10. UNDER 1 year Months 1 Days 1	11. UNDER 24 hrs Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typewriter mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Leeds, Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Henry Bennett		14. MOTHER'S MAIDEN NAME Elizabeth Victor Caldwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) W. War I		16. SOCIAL SECURITY No. 416-01-9588	
17. INFORMANT AND ADDRESS Elma Bennett		Wife	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause Coronary Thrombosis		
(b) Antecedent cause(s) Coronary Sclerosis		
(c) Cardiovascular renal disease		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE **John W. Maloney M.D.** (Degree or title) **Dep. Med. Exam. Cheverly, Md.** ADDRESS **Jan. 27, 1951** (State)

23. BURIAL, CREMATION, REMOVAL (Specify) **Burial** DATE THEREOF **Jan 29/51** NAME OF CEMETERY OR CREMATORY **Arlington Natl.** LOCATION (City, town, or county) **Arlington Va** (State)

DATE REC'D BY LOCAL REG. **Jan 28 1951** REGISTRAR'S SIGNATURE **James Severy** 24. FUNERAL DIRECTOR **F. Barco's Sons** ADDRESS **Hyattsville Md**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY: WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D. C.</u> COUNTY <u>-</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (Rural)</u>			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>			STREET ADDRESS (If rural, give location) <u>914 3rd St., N. W., Apt. #3</u>		
3. NAME OF DECEASED (Type or Print) <u>ANNA</u> (First) <u>MARTINA</u> (Middle) <u>BOWIE BENTLEY</u> (Last)			4. DATE OF DEATH <u>JAN.</u> (Month) <u>6</u> (Day) <u>1951</u> (Year)		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/24/1895</u>	9. AGE last birthday <u>55</u> yrs.	If under 1 year Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>		
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Frank Bowie</u>			14. MOTHER'S MAIDEN NAME <u>Julia Waters</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY No. <u>577-32-4094</u>		
17. INFORMANT AND ADDRESS <u>Decedent</u>					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

2 yrs. 8 mo.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JULY 9, 1948, to JAN 6, 1951, that I last saw the deceasedalive on JAN. 6, 1951, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Leo P. Pincane

M. D.

Glenn Dale Sanatorium1/6/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>removal</u>	<u>1/6/51</u>	<u>Glenn Dale, Maryland</u>	<u>Washington</u>	<u>D.C.</u>
DATE REC'D BY LOCAL REG.	REGISTER'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/6/51</u>	<u>W. W. W.</u>	<u>Carver Memorial Funeral Home</u>	<u>29 14 St. N.W., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

720826

RECEIVED
JUN 15 1951
REAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0734

Reg. Dist. No. 231

1. PLACE OF DEATH- COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL, and OR give nearest town) TOWN <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ritchie</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's General Hospital</u>		STREET ADDRESS (If rural, give location) <u>8351 White House Road</u>	
3. NAME OF DECEASED (First) <u>Harvey</u> (Middle) <u>Brady</u> (Last) <u>Brady</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 3, 1931</u> 19 <u>19</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>George Washington Brady</u>		14. MOTHER'S MAIDEN NAME <u>Annie S. Redwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
819.5 Immediate cause (a) <u>Cerebral compression</u>		
170c Antecedent cause(s) (b) <u>Post operative hemorrhage</u>		
(c) <u>Fracture of the base of the skull</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of the left femur</u>		
19a. DATE OF OPERATION <u>1/24/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Decompression of the posterior cerebral fossa</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>State Road</u>	(CITY OR TOWN) <u>Largo</u> (COUNTY) <u>P. G.</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>4</u> <u>51</u> <u>5:20</u>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>object</u> <u>Driver of a truck that struck a fixed</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>James D. Boyd</u> M. D. Forestville, Md.		DATE SIGNED <u>1/24/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>2400 51</u>	NAME OF CEMETERY OR CREMATORY <u>Ritchie Funeral Home</u>	LOCATION (City, town, or county) (State) <u>Marlboro, Upper Marlboro, Md.</u>
DATE REC'D BY LOCAL REG. <u>1/24/51</u>	REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

270A

RECEIVED
MAY 30 1951
B. A. L. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Taurol</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
TOWN <u>Taurol</u>		TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taurol Sanitarium</u>		STREET ADDRESS <u>35 Northwest St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Bennet Bernard Browne</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-4-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Bennet Bernard Browne</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Nicholas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u> (If year, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Dr. Mary H. Browne 2845 N. Calvert St. Balto.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic Myocarditis</u>		<u>Several years</u>
Antecedent cause(s) (b) <u>Chronic Endocarditis</u>		" "
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>		" "
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia Praecox</u>		<u>26 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-15-, 1949, to 1-25-, 1951, that I last saw the deceased alive on 1-25-, 1951, and that death occurred at 6:25 a.m., from the causes and on the date stated above.

SIGNATURE James P. Sands M.D. Taurol Sanitarium, Taurol, Md. DATE SIGNED 1-25-1951

23. BURIAL OR REMOVAL (Specify) <u>BURIAL</u>	DATE <u>JAN. 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>	LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD.</u>
DATE REC'D BY LOCAL REG. <u>1-26-51</u>	REGISTRAR'S SIGNATURE <u>L</u>	24. FUNERAL DIRECTOR <u>H.W. JENKINS & SONS Co.</u>	ADDRESS <u>4905 YORK RD</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

075868

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
in #18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

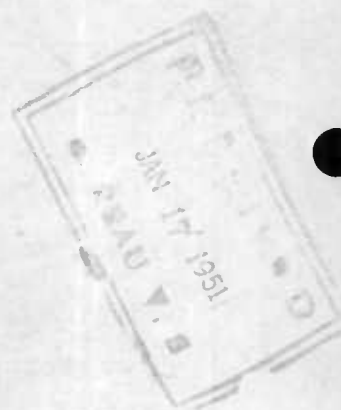
CERTIFICATE OF DEATH

Reg. Dist. No. 242

FILE No. G 130 JAN 19 1951

1. PLACE OF DEATH COUNTY Prince Geo's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Geo's	
CITY (If outside corporate limits, write RURAL and give nearest town) District Heights		CITY (If outside corporate limits, write RURAL and give nearest town) District Heights	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS 7 Delano Drive	
3. NAME OF DECEASED (Type or Print) Harry (First) G. (Middle) Buckbee (Last)		4. DATE OF DEATH 1 (Month) 11 (Day) 1951 (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 22, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Gun Factory	9. AGE last birthday 50. yrs.
13. FATHER'S NAME Edward J. Buckbee		11. BIRTHPLACE (State or foreign country) Illinois	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		14. MOTHER'S MAIDEN NAME Minnie Grimes	
16. SOCIAL SECURITY No. 1919		17. INFORMANT AND ADDRESS Mrs. Harry G. Buckbee - Spouse, District Heights, Md.	
18. MEDICAL CERTIFICATION		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Acute Myocardia Decompensation		20 min.	
Antecedent cause(s) (b) Tumor of Pancreas		6 yrs	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Organ Head of Pancreas not malignant (1/22/51 akc)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none of note			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) natural		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
SUICIDE		(STATE)	
HOMICIDE		(CITY OR TOWN)	
TIME (Month) (Day) (Year) (Hour)		(COUNTY)	
INJURY OF INJURY m.		HOW DID INJURY OCCUR?	
PLACE (Home, farm, factory, street, office bldg, etc.)		(CITY OR TOWN)	
INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		(COUNTY)	
22. I hereby certify that I attended the deceased from June 19, 1945, to Jan 11, 1951, that I last saw the deceased alive on Jan 11, 1951, and that death occurred at 8:30 a.m., from the causes and on the date stated above.			
SIGNATURE Paul C. Van Hatten		ADDRESS 5440 Silver Hill Road SE Washington D.C.	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE 1/15/51	
NAME OF CEMETERY OR CREMATORY Springfield		LOCATION (City, town, or county) Danville, Illinois	
DATE REC'D BY LOCAL REG. Jan 11 - 1951		24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.	
REGISTRAR'S SIGNATURE Edward F. Collins		ADDRESS	

544 346



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (RURAL)		LENGTH OF STAY (in this place) 2 yrs. 4 mo.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium				STREET ADDRESS 1685 Crescent Pl., N.W.			
3. NAME OF DECEASED (Type or Print) CAMILLE		(First) (Middle) A.		(Last) BUNNELL		4. DATE OF DEATH JAN. 26 1951	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED		8. DATE OF BIRTH 7/13/92	
				9. AGE last birthday 58 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Memphis, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luke Campbell				14. MOTHER'S MAIDEN NAME Catherine Kerans			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 578-36-0277		17. INFORMANT AND ADDRESS Decedent			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

2 yrs 6 mo

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?							

22. I hereby certify that I attended the deceased from AUG. 30, 1948, to JAN. 26, 1951, that I last saw the deceased alive on JAN. 26, 1951, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

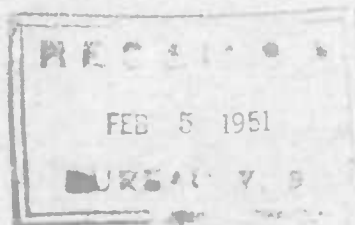
DATE SIGNED

23. BURIAL OR CREMATION REMOVAL (Specify)		DATE THEREOF 1/29/51		NAME OF CEMETERY OR CREMATORY Mt. Olivet D.C.		LOCATION (City, town, or county) Washington		(State) D.C.	
DATE REC'D BY LOCAL REG. 1/27/51		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Timothy Hanlon		ADDRESS 641 H. Street, D.C.			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0738

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u> LENGTH OF STAY (In this place) <u>5 years</u> TOWN <u>Cedar Heights</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6402 Lee Place</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u> OR TOWN <u>Cedar Heights</u> STREET ADDRESS (If rural, give location) <u>6402 Lee Place</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>Burgess</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>Jan</u> (Month) <u>5</u> (Day) <u>1951</u> (Year)	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 16, 1902</u> 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home making of furniture</u>	11. BIRTHPLACE (State or foreign country) <u>Marlboro, Md</u>
13. FATHER'S NAME <u>Robert Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna Early</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Harry S. Stuart - Sister</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Acute congestive heart failure</u>		
Antecedent cause(s) (b) <u>Tuberculosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Lobar Pneumonia</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

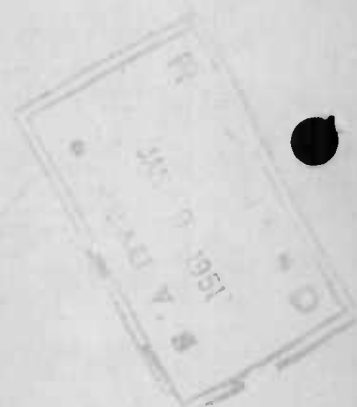
SIGNATURE <u>John W. Maloney M.D.</u>	DATE SIGNED <u>1-5-51</u>
ADDRESS <u>Dep. Med. Exam. Choverly Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/9/51</u>
NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
DATE REC'D BY LOCAL REG. <u>Jan 6, 1951</u>	REGISTRAR'S SIGNATURE <u>Harrie F. Campbell</u>
24. FUNERAL DIRECTOR <u>Henry S. Washington & Sons</u>	ADDRESS <u>467 N ST. N.W.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

510 246



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY Prince Georges		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Glenn Dale (RURAL)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium		STREET ADDRESS (If rural, give location) 919- 6'th St., S.E.	
3. NAME OF DECEASED (Type or Print) Herman		4. DATE OF DEATH (Month) 1 (Day) 26 (Year) 1951	
5. SEX male	6. COLOR OR RACE negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Dec 27, 1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping clerk		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME William Burns		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		17. INFORMANT AND ADDRESS Decedent	
16. SOCIAL SECURITY NO. 578-12-3700		14. MOTHER'S MAIDEN NAME Lula Robinson	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Renal Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

2 yrs 10 mos

Antecedent cause(s)

(b)

with terminal uremia

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Pulmonary Tuberculosis

12 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)

SUICIDE
HOMICIDEPLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11, 28, 1947, to 1. 26, 1951, that I last saw the deceased

alive on 1. 26, 1951, and that death occurred at 7:10 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Leo Pinecone M.D.

Glenn Dale Sanatorium

1/26/51

Glenn Dale, Md.

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG. 1/26/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

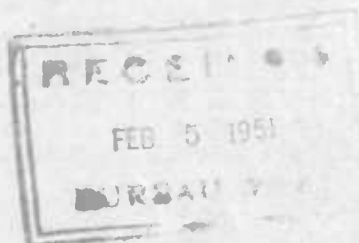
Malvan & Schey, 424 R. Street N.W.

342 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH: Prince Georges
County.....
City or town..... Farmount Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 60 days
Hospital, institution, or street address where death occurred:
704 - 59" Ave.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... County.....
City or town..... Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1278 Morse St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

James Everett Butler

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... Negro 6. (a) Single, married, widowed, or divorced..... married
6. (b) Name of husband or wife..... Gertrude Gola
Butler 6. (c) If alive, give age..... 37 years
7. Birth date of deceased (mo., day, yr.)..... Feb. 2, 1906
8. AGE: Years..... 44 Months..... 11 Days..... hrs..... min.....

9. Birthplace..... Oxon Hill, Md.
(Town, county, and state)

10. Usual occupation..... Cook

11. Industry or business..... Cafe

12. Name..... James Butler

13. Birthplace..... Prince Georges County

14. Maiden name..... Lillie Irene Butler

15. Birthplace..... Prince Georges County

16. Informant..... Mrs. Gertrude Butler

Address..... 1278 Morse St. N.E.

17. Removal Date thereof..... Jan. 16, 1951
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Washington D.C.

18. Funeral director..... Henry S. Washington & Sons

Address..... 467 "N" St. N.W. D.C.

19. Jan. 16 19 51 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 16, 1951 at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Dec. 19, 50 to..... Jan. 16, 1951

and that I last saw him alive on..... Jan. 16, 1951

Immediate cause of death..... Status Epilepticus

Due to..... Nervous Exhaustion

Due to..... Alcoholism

Other conditions.....

322.2 (Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?.....

23. SIGNATURE..... John Robinson, M.D.
M. D. or other.....

Address..... 1001 Eastern Ave. Date signed..... 1/16/51

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 19 1951
C. REAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. *245*

1. PLACE OF DEATH COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>P.G.Co.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brattonville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Laurel Route 2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>New Hampshire Ave - 300 ft. from Montgomery Rd</i>		STREET ADDRESS (If rural give location) <i>Fort Meade Road</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Jesse</i> (Middle) <i>Cabell</i> (Last) <i>Campbell</i>	4. DATE OF DEATH	Month <i>Jan</i> (Day) <i>10</i> (Year) <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 13, 1929</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Slaborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Timber cutting</i>	9. AGE last birthday <i>21</i> yrs.	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>Elmer Campbell</i>	14. MOTHER'S MAIDEN NAME <i>Edna Campbell</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>224-26-1054</i>	17. INFORMANT <i>Margaret Campbell - Wife</i>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
910.8 Immediate cause (a) <i>Cerebral Compression</i>		
175.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <i>Intracranial hemorrhage</i>		
(c) <i>Fractured skull</i>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Woods</i>	(CITY OR TOWN) <i>Near Patuxent Park, P.G. Co., Md.</i> (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>1-10-51-1:20 p.m.</i>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>Struck by falling limb of tree while at work.</i>

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <i>John D. Maloney M.D.</i>	DATE SIGNED <i>Jan 10, 1951</i>	ADDRESS <i>Cherry Hill, Md.</i>
23. BURIAL OR CREMATION REMOVAL (Specify) <i>Removal</i>	DATE THEREOF <i>Jan 11, 1951</i>	NAME OF CEMETERY OR CREMATORY <i>Corington</i>
DATE REC'D BY LOCAL REG. <i>Jan 11, 1951</i>	REGISTRAR'S SIGNATURE <i>James Severy</i>	24. FUNERAL DIRECTOR <i>F. Gasche Sons Hyattsville Md.</i>

950306

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Central Commission
Inter-Continental
Transportation

RECEIVED
JAN 15 1951
RECEIVED
JAN 15 1951

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 245

0742

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Berwyn</u> LENGTH OF STAY (in this place) <u>4 years</u> TOWN <u>Berwyn</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Metzgerott Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Berwyn</u> TOWN <u>Berwyn</u> STREET ADDRESS (If rural, give location) <u>Metzgerott Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>Norman</u> (Middle) <u>Clark</u> (Last)		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov 5, 1942</u>
9. AGE last birthday <u>8 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>	
11. BIRTHPLACE (State or foreign country) <u>Mussonville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Norman Clark</u>		14. MOTHER'S MAIDEN NAME <u>Mary Francis Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>John Loe - Step-father</u>			

18. MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH (a) <u>Hemorrhage & shock</u> (b) <u>Gunshot wound of chest</u> (c) <u>Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		INTERVAL BETWEEN ONSET AND DEATH
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11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION <u>Jan 14, 1951</u>	19b. MAJOR FINDINGS OF OPERATION		21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTRIBUTING
TIME (Month) (Day) (Year) (Hour) <u>1-14-51 P. m.</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Shot accidentally by 6 year old brother</u>

22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input checked="" type="checkbox"/> undetermined <input type="checkbox"/>.			
SIGNATURE <u>John W. Maloney, M.D., Dep. Med Exam</u>		DATE SIGNED <u>Jan 17, 1951</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	
DATE REC'D BY LOCAL REG. <u>Jan 16, 1951</u>		REGISTRAR'S SIGNATURE <u>James Leroy</u>	
24. FUNERAL DIRECTOR <u>J. Pasche</u>		ADDRESS <u>1400 N. Fayetteville Rd</u>	

MARLIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Farmount Heights</u> TOWN <u>13 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Farmount Heights</u> TOWN <u>13 years</u> STREET ADDRESS (If rural give location) <u>705-59-Pl</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary</u> <u>Clark</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan</u> <u>16</u> <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1880</u>
9. AGE last birthday <u>71</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Barney West</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Leander E. Clark</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>331x</u> <u>Antecedent cause(s)</u> <u>83a</u> <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	(a) <u>Cerebral Hemorrhage</u> (b) <u>Hypertension</u> (c)	<u>2 1/2 Mo</u> <u>7</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 29, 1956, to Jan 16, 1957, that I last saw the deceased alive on Jan 16, 1957, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

SIGNATURE <u>H. B. Belloy MD</u>	(Degree or title)	ADDRESS <u>4823-Hunt Pl. N.E. Washington D.C.</u>	DATE SIGNED <u>1-16-57</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>Jan 16-57</u>	NAME OF CEMETERY OR CREMATORY <u>Washington D.C.</u>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>Jan 16-57</u>	REGISTRAR'S SIGNATURE <u>Carrie E. Campbell</u>	24. FUNERAL DIRECTOR <u>Henry S. Washington & Sons</u>	ADDRESS <u>467 "N" St. N.W. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 212

1. PLACE OF DEATH COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince George's	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltersville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs Maryland</u>	
TOWN <u>Willingboro</u>		TOWN <u>Silver Springs Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Willing School Fullerton</u>		STREET ADDRESS (If rural give location) <u>Colesville Road</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
	Horace	Truman	Clothier
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
male	white	married	5/30/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
Superintendent		Washington Sanitary Comm	59 years
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Virginia		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James S. Clothier		Irea M Stephenson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
no		105-20-3098	
17. INFORMANT		18. MEDICAL CERTIFICATION	
A. E. Clothier		428 Ingraham St N W Washington D. C.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Asphyxia</u>		
Antecedent cause(s) (b) <u>Drowning</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Slipped into reservoir while working</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg, etc.) <u>Fullerton</u>	(CITY OR TOWN) <u>Beltersville - P. George, Md.</u> (COUNTY) <u>Prince George's</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) <u>1-22-51 11:55 AM</u>	INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Accidentally fell into reservoir</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		
SIGNATURE <u>John D. Maloney, Jr. M.D. Dep. Med. Exm. Chvrbk, Md.</u>		DATE SIGNED <u>1-22-51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>Jan 25, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Maryland</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Jan 24, 1951</u>	24. FUNERAL DIRECTOR <u>John B. Hilton</u>	ADDRESS <u>250 597</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Hts.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Hts.</u>	
TOWN <u>Fairmont Hts.</u>		TOWN <u>Fairmont Hts.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>715-61st Ave</u>		STREET ADDRESS <u>715-61st Ave</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Annie</u> (Middle) <u>Eliza</u> (Last) <u>Coates</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 25/1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General housework</u>	9. AGE last birthday <u>68</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Charles County, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13. FATHER'S NAME <u>Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Alice Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Harry Coates - Husband</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause (a) <u>Hypertensive Cardiac Disease</u>			<u>2 yrs</u>
93d Antecedent cause(s) (b) <u>Parkinson's Disease Hypertension</u>			<u>8 yrs</u>
(c) <u>Parkinson's Disease</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

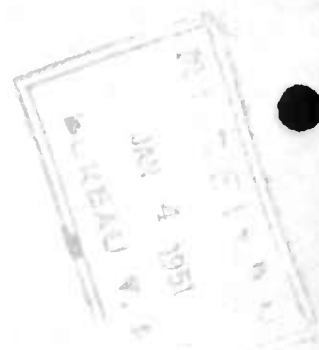
22. I hereby certify that I attended the deceased from June, 1947, to Dec 31, 1950, that I last saw the deceased alive on Dec 28, 1950, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

SIGNATURE John W. Rount (Degree or title) M.D. ADDRESS 330-61st St DATE SIGNED Jan 1st, 1951

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>1-5-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Shimon Cem.</u>	LOCATION (City, town, or county) (State) <u>Croome, Pr Geo. Co. Md</u>
DATE REC'D BY LOCAL REG. <u>Jan 1-1951</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>Henry S. Washington & Sons</u>	ADDRESS <u>467 N. E. Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1746 24/5

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Leland Memorial Hosp.</u>		STREET ADDRESS <u>1923 Summit Pl. N.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>Gertrude</u> (First) <u>Cook</u> (Last)		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>May 17/1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>60</u> yrs.
13. FATHER'S NAME <u>JOHN MINSHEW</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give year or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>GOLDEN COOK - 1923 SUMMIT PL. N.E. WASH. D.C.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
157x Immediate cause (a) <u>Congestive failure</u>		
46g Antecedent cause(s) (b) <u>Arteriosclerotic cardiac disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Carcinoma of the Pancreas</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1950, to Jan. 18, 1951 that I last saw the deceased alive on Jan. 18, 1951, and that death occurred at 3:20 A.m., from the causes and on the date stated above.

SIGNATURE Harry P. Hadley, M.D. (Degree or title) ADDRESS 1252--6th St. S.W. Wash. D.C. DATE SIGNED 1/19/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>JAN 22/1951</u>	NAME OF CEMETERY OR CREMATORY <u>FREMONT CEMETERY</u>	LOCATION (City, town, or county) <u>FREMONT, N.C.</u> (State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe (Deputy) Local</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>	ADDRESS <u>Riverdale, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1747

745

1. PLACE OF DEATH- COUNTY <i>Pr. Geo. Hyatts Vill</i> <i>4004 Queensburg Rd</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hyattsville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>4004 Queensbury Rd</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>FLOSSIE</i>	(Middle) <i>ANN</i>	(Last) <i>DANIELS</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>1991</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>70</i> yrs.
13. FATHER'S NAME <i>William H Barney</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <i>Quinn Ann Adamsman</i>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <i>142X Cardio-vascular renal disease</i>		(a)	<i>6 yrs.</i>
Antecedent cause(s) <i>61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>		(b)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Diabetes Mellitus</i> <i>Diabetic Neuropathy</i>		(c)	<i>10 yrs</i> <i>1 yr. 6 mon</i>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Feb. 17, 1945*, to *Jan. 13, 1951*, that I last saw the deceased alive on *Jan. 13, 1951*, and that death occurred at *6:45 A.M.*, from the causes and on the date stated above.

SIGNATURE *J. C. Bowman, M.D.* (Degree or title) ADDRESS *4021-18th St. N.E., Washington, D.C.* DATE SIGNED *Jan. 13, 1951*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>1-15-51</i>	<i>1-15-51</i>	<i>Fort Lincoln Cem.</i>	<i>MARYLAND</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>1-15-51</i>	<i>Amanda Barney</i>	<i>Timothy Heale</i>	<i>641 H St N.E.</i>	
<i>1-16-51</i>	<i>James Servey</i>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for changes
in #7 & #8 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0748 245

FILM No. G 130 JAN 19 1951

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 51

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 15 1951 19 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1950 to Jan 15 1951

and that I last saw him alive on Jan 14 1951

Immediate cause of death

DURATION

Congestive heart failure 2 weeks

Due to

Due to

Other conditions

420.0

73d

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

JAN 15 1951



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (Rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium		STREET ADDRESS D.C. Home for Aged, Blue Plains	
3. NAME OF DECEASED (Type or Print)	(First) EDWARD	(Middle) E	(Last) DIVVER SR.
6. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 1-15-1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Co., lineman		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE last birthday 75 yrs.
11. BIRTHPLACE (State or foreign country) Prince Georges Co., Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Divver		14. MOTHER'S MAIDEN NAME Mary Mack	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. (lost)	
17. INFORMANT AND ADDRESS Decedent			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

1 yr 6 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2-27-1949, to 1-20-1951, that I last saw the deceased

alive on 1-20-1951, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Glenn Dale Sanatorium		Glenn Dale, Maryland		1/20/51
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF 1/23/51	NAME OF CEMETERY OR CREMATORY Washington National Cemetery	LOCATION (City, town, or county) Prince Georges County	(State) Maryland
DATE REC'D BY LOCAL REG. 1/21/51	REGISTRAR'S SIGNATURE Helen Weiss	24. FUNERAL DIRECTOR W.H. Chambers Co	ADDRESS 517 11th St N.E. DC	

540578

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for changes
in 8 & 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6750

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH: COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Pr. George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Friendly (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Friendly (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7850 Old Fort Rd. S.E.</u>		STREET ADDRESS (If rural, give location) <u>7850 Old Fort Rd. S.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>Katherine V. Donaldson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 27 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug 24, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>76 1/4</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ed (7) Wm E. Green</u>		14. MOTHER'S MAIDEN NAME <u>Alice Sarah E. Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Katherine V. Logan</u>			

13. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Brights Disease

INTERVAL BETWEEN ONSET AND DEATH

one month

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio-Sclerotic Heart Disease

several

(c) Hypertension, Cardiac Decompensation

yes

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Fell down stairs at death occurred (Reported to coroner)

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-19, 1957, to 1-27, 1957, that I last saw the deceased

alive on 1-25, 1957, and that death occurred at 5:40 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Anna Coyne Todd, M.D.

7274 Palmer Rd S.E.

1-27-57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan 30, 1957</u>	<u>Columbian</u>	<u>Farmers Arlington</u>	<u>Va</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 27-1957</u>	<u>Howard J. Beall</u>	<u>Geo W. Ware Co</u>	<u>2900 Mt NW Wash DC</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

105-240

1. PLACE OF DEATH:

County Prince George
 City or town Westwood Md (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 yrs
 Hospital, institution, or street address where death occurred:
Westwood, Md (Rural)
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Westwood (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Westwood Md
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

George Francis Dwyer

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

5-4316

hrs.

min.

9. Birthplace

Westwood Md Prince George
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FarmingMOTHER
FATHER

12. Name

Voseph Dwyer

13. Birthplace

Unknown

14. Maiden name

Chariot Jenkins

15. Birthplace

MARYLAND

16. Informant

John O. Townsend

Address

Westwood, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1-8-50
(month) (day) (year)

Cemetery or crematory

St Philip

Location

Rural Agnassco md

18. Funeral director

Hunt & Ryan

Address

Walden J md

19. (Date rec'd by registrar)

1-6

19

51Mr. R. Mowbray
Jan 4, 1951
7 N. Hollins St.
Baltimore

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 5 1951 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 19 50 to JANUARY 19 51
 and that I last saw him alive on JANUARY 4 1951

Immediate cause of death Coronary thrombosis

DURATION

Due to Congestive heart failureDue to Hansen virusOther conditions Hansen virus420.1

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) None

Means of injury _____ Injured at work?

23. SIGNATURE

Clifton R. Hines, M.D.

M. D. or other

Address

Box 261 Upper Marlboro MdDate signed JAN 5 1951

100105

RECEIVED
JAN 11 1951
FBI

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

0752 232

Reg. Dist. No. 545

1. PLACE OF DEATH- COUNTY <i>Px Geo</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Ind</i> COUNTY <i>Px</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Upper Marlboro</i>		LENGTH OF STAY (in this place) <i>Life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Hills Bridge</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <i>Upper Marlboro, Ind</i>	
3. NAME OF DECEASED (Type or Print)		(First) <i>Verma</i>	(Middle)	(Last) <i>Eades</i>	4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>19</i> (Year) <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>		8. DATE OF BIRTH <i>About 1925</i>	9. AGE last birthday <i>22</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Upper Marlboro Ind</i>	
13. FATHER'S NAME <i>Samuel Eades</i>		14. MOTHER'S MAIDEN NAME <i>Jadie Emma</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT <i>Mother</i>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
351x Immediate cause (a) <i>Ungetive Heart Failure</i>		<i>3 days</i>
157e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Congenital Heart Disease</i>		<i>Life</i>
	<i>Cerebral Palsy - Birth injuries</i>	<i>Life</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Removal</i>	<i>1/20/51</i>	<i>University Hospital</i>	<i>Baltimore</i>	<i>Md.</i>

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>Jan. 19-1951</i>	<i>Edna F. [Signature]</i>	<i>Ritchie Bros.</i>	<i>Upper Marlboro, Md.</i>

R.R. Smith

VVVVV

VS. A15A



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1175405

1. PLACE OF DEATH:

County Prince George's
 City or town Brown Square Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Mary Maudle Carly

4. Sex Female 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 20 - 1882

8. AGE: Years 68 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Brown Square Md
 (Town, county, and state)

10. Usual occupation

11. Industry or business MS. Shoemaking Clerk

12. Name Charles S Carly

13. Birthplace Prin Co

14. Maiden name Georgea H Berry

15. Birthplace Prin Co

16. Informant Charles B Carly

Address Brown Square Md

17. Burial Date thereof 1-16-51
 (Burial, cremation, or removal. When)

Cemetery or crematory St Paul

Location Baden Md

18. Funeral director Hendrick & Ryon

Address Waldorf Md

19. 1-15 19 51 M. R. Moore
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Prince Geo
 City or town Brown Square Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1951 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1937 to Jan 13 1951

and that I last saw him alive on Jan 12 1951

Immediate cause of death Myocardial Apoplexy

Due to Cardio-Vas Disease

Due to Arthritis deformans

Other conditions 442X

(Include pregnancy within 3 months of death)

Major findings of operations 131a

Date of op. _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. D. Weber M.D.

Address Waldorf Md Date signed 11-17-51

12-12-12 5:10 AM
12-12-12 5:10 AM
12-12-12 5:10 AM

12-12-12 5:10 AM
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12-12-12 5:10 AM
12-12-12 5:10 AM
12-12-12 5:10 AM



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>District of Columbia</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
TOWN <u>3 days</u>		TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's General Hospital</u>		STREET ADDRESS (If rural, give location) <u>16 Henry Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John B Elliott</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 31 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>	8. DATE OF BIRTH <u>Feb 12, 1889</u>
9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Tropp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Bessie Hall</u>	
17. INFORMANT <u>Bessie Hall</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>442x Uremia</u>		
(b) Antecedent cause(s) <u>131a Cardiovascular renal disease</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1949 to Jan 31, 1957, that I last saw the deceased alive on Jan 31, 1957, and that death occurred at 3:30 P from the causes and on the date stated above.

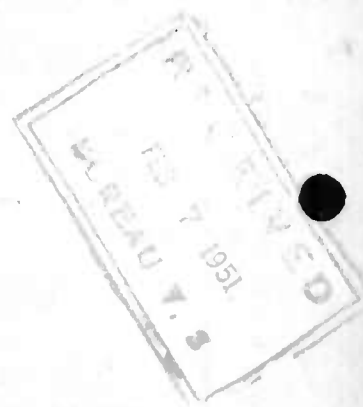
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
James D. Boyd M.D. Forestville Md 1-31-57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb 3-1957</u>	<u>Cedar Hill Cemetery</u>	<u>Annapolis</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 31-1957</u>	<u>Edna F. Collins</u>	<u>W. W. Chambers Co.</u>	<u>517-11 St S. E.</u>	

730869

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cheverly -</u> TOWN <u>2mo. 2 day</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Gen Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> TOWN <u>4409 - 37th St.</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elizabeth</u>	(Middle)	(Last) <u>Fahay</u>
6. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>8 Mar 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>69</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Michael M. Gann</u>	14. MOTHER'S MAIDEN NAME <u>Catherine Mallant</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Chronic Congestive Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

2 mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Diabetes Mellitus9Arteriosclerotic Heart Disease5 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.General Debility, secondary anemia

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 11-6, 1950, to 1-12, 1951, that I last saw the deceasedalive on 1-11, 1951, and that death occurred at 5:02 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>1-13-51</u>	<u>Cumberland, Md.</u>	<u>641 3rd St NE</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1-12-51</u>	<u>Amanda Downey</u>	<u>Smithy Park Funeral Home</u>	<u>641 3rd St NE</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH- COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Riverdale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Riverdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Leland Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>4000 Queensbury Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Marie</u> (First) <u>Columbia</u> (Middle) <u>Felter</u> (Last)		4. DATE OF DEATH <u>Jan 15</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug 15 1892</u> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office employee Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post office</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Wilson Watkins</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Lee Mathis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Chart</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
592x Immediate cause (a)	<u>Cerebral Hemorrhage</u>		<u>1 day</u>
61 Antecedent cause(s) (b)	<u>General arteriosclerosis</u>		<u>10 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	<u>Chronic Glomerular Nephritis</u>		<u>10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS	<u>Diabetes</u>		<u>4 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
SUICIDE HOMICIDE	INJURY		(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 15, 1951, to Jan 15, 1951, that I last saw the deceased alive on Jan 15, 1951, and that death occurred at 6:05 a.m., from the causes and on the date stated above.

SIGNATURE Dr. William M. D. ADDRESS Riverdale, Md DATE SIGNED 1-15-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan 18, 1951</u>	<u>Cedar Grove Cemetery</u>	<u>Cedar Grove Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 16, 1951</u>	<u>James Severy</u>	<u>L. Pasche Son Hyattsville Md</u>		

390906

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>B. Geo</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Berwyn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's General Hosp.</u>		STREET ADDRESS (If rural, give location) <u>5,000 Hollywood Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>HARRY</u>	(First) <u>IRVING</u>	(Middle) <u>Fletcher</u>	(Last)
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 17, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bloodsmith Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Yard</u>	9. AGE last birthday <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM LEE FLETCHER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ANN JENKINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>579-18-6727A</u>	
17. INFORMANT AND ADDRESS <u>MARY P FLETCHER, 5000 HOLLYWOOD RD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Toxemia, Multiple Septic Infarctions of the spleen, kidney, and aorta</u>			
Antecedent cause(s) (b) <u>Brachopneumonia</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic cystitis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes, Carcinoma of Prostate</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1/22, 1951, to 1/31, 1951, that I last saw the deceased alive on 1/30, 1951, and that death occurred at 11:00 A m., from the causes and on the date stated above.

SIGNATURE Dr. E. Elieuvre M.D. (Degree or title) ADDRESS College Park, Md DATE SIGNED 1-31-51

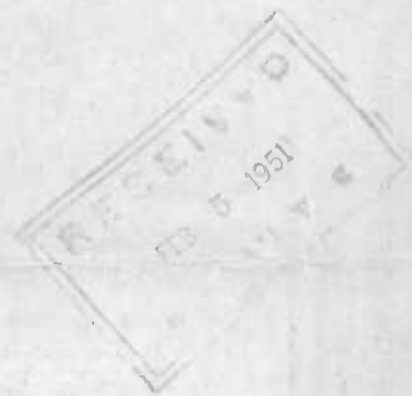
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>FEB 2, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	LOCATION (City, town, or county) <u>SUITLAND</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>2-1-51</u>	REGISTRAR'S SIGNATURE <u>Amanda Sawney</u>	24. FUNERAL DIRECTOR <u>WW CHAMBERS CO, RIVERPALE, MD</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

501346



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *215*

1. PLACE OF DEATH COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hyattsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hyattsville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>6403 Ager Road</i>		STREET ADDRESS (If rural, give location) <i>6403 Ager Road</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>LINDA</i> (Middle) <i>JEAN</i> (Last) <i>FRANZEN</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>January 17th, 1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>April 27/1950</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE last birthday (If under 1 year, give month, day, hour, min.) <i>8 Months, 21 Days</i>
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George John Franzen</i>		14. MOTHER'S MAIDEN NAME <i>Lee Jeannette LaFaro</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No. <i>none</i>	
17. INFORMANT AND ADDRESS <i>George J. Franzen, Wash. D.C.</i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
325.4 Immediate cause (a) <i>Congenital Heart Disease</i>			<i>since birth</i>
Antecedent cause(s) (b) <i>Scurvy</i>			<i>since birth</i>
157e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Scurvy</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 4, 1950*, to *Jan. 17, 1951*, that I last saw the deceased alive on *Jan 16, 1951*, and that death occurred at *6:05 P.m.*, from the causes and on the date stated above.

SIGNATURE (Degree or title) *Thomas A. Christensen MD* ADDRESS *6905 Baltimore Ave. College Park, Md* DATE SIGNED *1/17/51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>Jan. 19/1951</i>	NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
DATE REC'D BY LOCAL REG. <i>Jan 18, 1951</i>	REGISTRAR'S SIGNATURE <i>James Severy</i>	24. FUNERAL DIRECTOR <i>W.W. Chambers Company</i>	ADDRESS <i>Riverdale, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY <u>Prince George's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> TOWN <u>Beltsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Belmont Memorial Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> TOWN <u>Beltsville</u> STREET ADDRESS (If rural, give location) <u>4718 - Muskrug</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Anna Maholda Fuller</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 25 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr 21, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Morris Anthony Weiss</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ross Diller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital records</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>Shock</u>			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Postoperative hemorrhage</u>			
(c) <u>Carcinoma of head of pancreas</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>John D. Maloney, M.D.</u>		DATE SIGNED <u>Jan 29 1951</u>	
ADDRESS <u>Dep. Med. Examin - Chevy Chase, Hyattsville Md</u>			
3. BURIAL, CREMATION, REMOVAL? (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 29 1951</u>	<u>Fort Lincoln</u>	<u>Prince George's</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>Jan 29 - 1951</u>	<u>James C. Seren</u>	<u>Red Gray Selby 401 Wash. Ave</u> <u>Laurel Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 275

1. PLACE OF DEATH- COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Roger Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Roger Heights, Hyattsville, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5400-Gallatin street</u>		STREET ADDRESS (If rural, give location) <u>5400-Gallatin street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Donald</u> (Middle) <u>E.J.</u> (Last) <u>Gaarder</u>	4. DATE OF DEATH	(Month) <u>Jan.</u> (Day) <u>6</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/3/1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't.</u>	9. AGE last birthday <u>40</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>St. Ansgar, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Gaarder</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gunderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Goldie Gaarder (Wife)</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial Infarction - Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

5 min.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Previous Myocardial Infarction

2 years

(c) Arteriosclerotic Heart Disease

2 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify) None

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1948, to Mar, 1950, that I last saw the deceased

alive on Mar 23, 1950, and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Arthur B. Rosenbaum

M.D.

1328 Eye St N.W. Wash

1/6/51

23. BURIAL CREMATION

(Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 8, 1951

Mrs. Jas. Severn (Deputy)

Fort Lincoln Cemetery

Colmar Manor, Md.

000916 3200-R, P. Ave. Mt. Rainier, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Coroner notified and will approve.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0761

Reg. Dist. No. 2464

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ohio</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ritchie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>539 South Wayne Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>On Uncle's Farm</u>		STREET ADDRESS (If rural give location) <u>Piqua Ohio</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Alon</u> <u>Salvatore</u> <u>Gentile</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January</u> <u>28</u> <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>married</u>	8. DATE OF BIRTH <u>12/6/20</u>
9. AGE last birthday <u>30</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patsy Gentile</u>		14. MOTHER'S MAIDEN-NAME <u>Josephine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>U.S.A.</u>		16. SOCIAL SECURITY NO. <u>U.S. Airforce records</u>	
17. INFORMANT <u>U.S. Airforce records</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Shock</u>			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Multiple crushing and burning wounds of body</u>			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>Ritchie</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>28</u> <u>51</u> <u>3:30 P.M.</u>		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Plane crash</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>James J. Rough M.D.</u>		DATE SIGNED <u>Jan. 29, 51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>Jan. 30, 51</u>	
NAME OF CEMETERY OR CREMATORY <u>Forestville Md</u>		LOCATION (City, town, or county) (State) <u>Columbus Ohio</u>	
DATE REC'D BY LOCAL REG. <u>1-28-51</u>		24. FUNERAL DIRECTOR <u>Walter Funeral Home</u>	
REGISTRAR'S SIGNATURE <u>Alma R. Hall</u>		ADDRESS <u>301 E. Capital St. Wash. D.C. 59596</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change
in age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILE No. G 130 FEB 14 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 23/

1. PLACE OF DEATH- COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD COUNTY Prince George	
CITY (If outside corporate limits, write RURAL and give nearest town) Buntwood		CITY (If outside corporate limits, write RURAL and give nearest town) Laurel R. Md.	
TOWN Buntwood		TOWN Laurel R. Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) Richard Gibson		4. DATE OF DEATH Jan 27 1957	
5. SEX Male		6. COLOR OR RACE Colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH May 25 1878	
9. AGE last birthday 78 yrs.		10. If under 1 year Months Days	
11. BIRTHPLACE (State or foreign country) Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nelson, Thomas		14. MOTHER'S MAIDEN NAME Sofia Gibson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No.	
17. INFORMANT Ida Cager			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
442x Immediate cause (a) Acute Cordial Dilatation	Interval BETWEEN ONSET AND DEATH 1 hr
131a Antecedent cause(s) (b) Chl. Myocarditis	10 yr
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Cardio renal Dis. Hypertension	5 yr
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

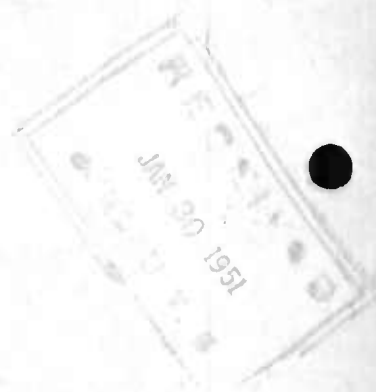
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)		22. I hereby certify that I attended the deceased from 1.2.10, 1936, to 1.2.7, 1957, that I last saw the deceased alive on 1.2.7, 1957, and that death occurred at 1.2.7, 1957, from the causes and on the date stated above.		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS			

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)		22. I hereby certify that I attended the deceased from 1.2.10, 1936, to 1.2.7, 1957, that I last saw the deceased alive on 1.2.7, 1957, and that death occurred at 1.2.7, 1957, from the causes and on the date stated above.		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS			
DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 26-1951 Amanda Horney

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 240

0763

1. PLACE OF DEATH- COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Prince Geo</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>6506-13 St. NE Maryland Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>BENJAMINE</u>			<u>GROVE</u>
6. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 9-1873</u>
			9. AGE last birthday <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sey</u>	11. BIRTHPLACE (State or foreign country) <u>Pittsburg PA</u>
13. FATHER'S NAME <u>William Grove</u>		14. MOTHER'S MAIDEN NAME <u>Lucy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
		17. INFORMANT AND ADDRESS <u>Unofficially 6506-13 St NE MD. Park</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>CEREBRAL HEMORRHAGE</u>		<u>2 months</u>
(b) Antecedent cause(s) <u>HYPERTENSION, MODERATE</u>		<u>2 years</u>
(c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		<u>not known</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 15, 1950, to Jan 18, 1951, that I last saw the deceased alive on Jan 18, 1951, and that death occurred at 3:05 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Emmett E. Coulson, MD

4400 Bonew Rd SE Wash DC Jan 18, 1951

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Jan 20-51</u>	<u>All Faith</u>	<u>Charlotte Hall Md</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1-19-51</u>	<u>M. R. Howard</u>	<u>Emmett & Ryan Wadley MD</u>	<u>106105</u>
<u>1-22-51</u>	<u>F. H. Billingsley</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Please fill out & mail To: —

1 Huntt & Ryon
Haldorf, Md.

Thanks —



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Washington D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Hospital</u>		STREET ADDRESS (If rural, give location) <u>727-7th St. N.E.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Ernestson Scanner Harold</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 30 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m.</u>	8. DATE OF BIRTH <u>Aug. 15 1890</u>
9. AGE last birthday <u>60</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationery Engineer Raleigh Hotel</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas J. Harlow</u>		14. MOTHER'S MAIDEN NAME <u>Alice E. Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Hora Harlow Washington D.C.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Portal Cirrhosis of Liver</u>		<u>6 months</u>
Antecedent cause(s)	(b) <u>Ruptured Esophageal Varix</u>		<u>3 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Hemorrhage & Shock</u>		<u>3 hours</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 28, 1951, to Jan. 30, 1951, that I last saw the deceased alive on Jan. 30, 1951, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE <u>Samuel N. Sugar</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>4300 Kaywood Drive Mt. Rainier Md. 1/30/51</u>	DATE SIGNED <u>1/30/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>2/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
DATE REC'D BY LOCAL REG. <u>Jan 31 1951</u>	REGISTRAR'S SIGNATURE <u>Amanda Dawney</u>	24. FUNERAL DIRECTOR <u>W. Pasche Sons Hyattsville Md.</u>	ADDRESS <u>Hyattsville Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

583836



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH- COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4105 Oliver St</u>		MARYLAND LENGTH OF STAY (in this place) <u>6 months</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Ind.</u> COUNTY <u>Pr. Ges.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> STREET ADDRESS (If rural, give location) <u>4105 Oliver Street</u>	
3. NAME OF DECEASED (Type or Print) <u>LEILA</u> (First) <u>ROOME</u> (Middle) <u>HARRIS</u> (Last)		4. DATE OF DEATH <u>Jan 2</u> (Month) <u>2</u> (Day) <u>1951</u> (Year)		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 25, 1894</u>	
9. AGE last birthday <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Rahway, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Shelton Oscar Roome</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret L. Covert</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Sam. Mercer Harris, 4105 Oliver St. Hyattsville Md.</u>					

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Vascular Disease

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1950, to Jan 2, 1951, that I last saw the deceased

alive on Dec 30, 1950, and that death occurred at 12:20 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 2 1951
James Leroy

J. Arthur Walters, 254 Carroll St. N.W. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 745

1. PLACE OF DEATH - COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>4015 Kennedy St</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Kyle</u> (Last) <u>Harrison</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Jan 27, 1888</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commissioner, Hyattsville Union Market</u>		11. BIRTHPLACE (State or foreign country) <u>Md, Beltsville</u>	
13. FATHER'S NAME <u>George Washington Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hopkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		17. INFORMANT AND ADDRESS <u>Lucille Harrison Hyattsville Md</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>US A</u>	
16. SOCIAL SECURITY NO. <u>none</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Uremia2 wks

Antecedent cause(s)

(b)

Arteriosclerotic and hypertensive cardio -

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

vascular renal diseaseYears11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Chronic glaucoma

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1950, to Jan 7, 1951, that I last saw the deceasedalive on Jan 6, 1951, and that death occurred at 7:10 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ronald S. FleischerM.D.5432 Queens Chapel Rd. Hyattsville1/7/51

23. BY RIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 8, 1951Mrs. Jas. Severe (Deputy)Lucille Harrison Hyattsville Md

290636

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *45*

1. PLACE OF DEATH COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hyattsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hyattsville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>6000 Baltimore Ave.</i>		STREET ADDRESS (If rural, give location) <i>6000 Baltimore Ave.</i>	
3. NAME OF DECEASED (Type or Print) <i>THOMAS FRANCIS HOLDEN</i>		4. DATE OF DEATH (Month) <i>January</i> (Day) <i>18th</i> , (Year) <i>1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan. 23/1866</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. Gas Light</i>	9. AGE last birthday <i>84</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Holden</i>		14. MOTHER'S MAIDEN NAME <i>Catherine (Unknown)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If year, give war or dates of service) <i>none</i>		16. SOCIAL SECURITY No. <i>Unknown</i>	
17. INFORMANT AND ADDRESS <i>Kathryn L. Holden 6000 Balti. Ave. Hyattsville, Md.</i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <i>191x Cardiac dilatation</i>	(a)	
Antecedent cause(s) <i>53 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>	(b) <i>carcinoma of chest</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>none</i>		(c)

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Dec 16* 19*50*, to *Jan 18* 19*51*, that I last saw the deceased alive on *Jan 18* 19*51*, and that death occurred at *7:45 AM*, from the causes and on the date stated above.

SIGNATURE <i>James S. Searcy</i>		ADDRESS <i>Hyattsville, Md.</i>		DATE SIGNED <i>1/18/51</i>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>1/20/1951</i>	NAME OF CEMETERY OR CREMATORY <i>Port Lincoln Cemetery</i>	LOCATION (City, town, or county) <i>Colmar Manor, PR. GEO. Md.</i>	(State)
DATE REC'D BY LOCAL REG. <i>Jan 18, 1951</i>		REGISTRAR'S SIGNATURE <i>James Searcy</i>		24. FUNERAL DIRECTOR <i>W.W. Chambers Company, Riverdale, Md.</i>

583 588

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 22 1951
- PRAY V. B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH COUNTY <u>Clinton</u> <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
TOWN <u>"</u>		TOWN <u>"</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>"</u>		STREET ADDRESS <u>"</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>James</u> (First) <u>Albert</u> (Middle) <u>JACKSON</u> (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>about 1878</u>
9. AGE last birthday <u>72?</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Air.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Jackson Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Frances Holliday</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Annie Johnson</u>		<u>Daughter.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>congestive heart failure</u>		
Antecedent cause(s) (b) <u>cardiovascular disease (arteriosclerosis)</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>hypertrophic prostate</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.

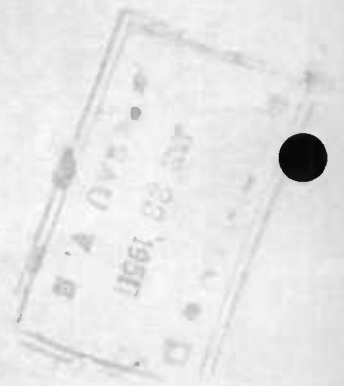
SIGNATURE Clifford L. Jones (Degree or title) ADDRESS Clinton, MD DATE SIGNED Jan 16, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1/16/51</u>	NAME OF SEMETERY OR CREMATORY <u>St. John's</u>	LOCATION (City, town, or county) <u>Clinton, MD</u>
DATE REC'D BY LOCAL REG. <u>1/16/51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Alton Davis</u>	24. FUNERAL DIRECTOR <u>W. Ernest J. J. J.</u>	ADDRESS <u>14320 9th St. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>Prince Geo. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Prince Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fairmont Hgts.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fairmont Hgts.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>605 Eastern Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u>	(First) <u>D.</u> (Middle) <u>Jackson</u>	(Last)	4. DATE OF DEATH <u>Jan. 18, 1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-28-75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>75</u> yrs. If under 1 year Months <u>11</u> Days <u>10</u> If under 24 hrs. Hours <u>10</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dallas Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Harriet ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT <u>Corrie Jackson - wife</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause (a) <u>Hypertensive Heart Disease</u>			<u>Indefinite</u>
93d Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 2, 1950, to Jan. 18, 1951, that I last saw the deceased alive on Jan. 18, 1951, and that death occurred at 8:20 a.m., from the causes and on the date stated above.

SIGNATURE <u>Maurice B. K. Edmond</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>4926 Central Ave. N.E. DC.</u>	DATE SIGNED <u>1/18/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>1-22-51</u>	NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	LOCATION (City, town, of county) <u>Surfside, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 20-51</u>	REGISTRAR'S SIGNATURE <u>Carrie J. Campbell</u>	24. FUNERAL DIRECTOR <u>Myrtle Rollins</u>	ADDRESS <u>4339 Hunt Pl. N.E. DC.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 24 1951
NEAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> TOWN <u>18 Months</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2613 Crest Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> TOWN <u>Cherry</u> STREET ADDRESS (If rural, give location) <u>2613 Crest Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth M. Connick</u>	(First) <u>Elizabeth</u>	(Middle) <u>M.</u>	(Last) <u>Connick</u>
4. DATE OF DEATH <u>Jan 5 1951</u>	(Month) <u>Jan</u>	(Day) <u>5</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 11 1876</u>
9. AGE last birthday <u>74</u> yrs.	If under 1 year Months <u>74</u> Days <u>74</u>	If under 24 hrs Hours <u>74</u> Min. <u>74</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas M. Connick</u>		14. MOTHER'S MAIDEN NAME <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Dorothy Chappell - Step daughter</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral accident</u>		
Antecedent cause(s) (b) <u>Cerebral arteriosclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE John J. Maloney, M.D., Dep. Med. Exam. ADDRESS Cherry - Hyattsville, Md. DATE SIGNED 1-5-51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 1/9/51 NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery LOCATION (City, town, or county) Southland Md. (State) Md.

DATE REC'D BY LOCAL REG. 1/6/51 REGISTRAR'S SIGNATURE Amanda Doney 24. FUNERAL DIRECTOR F. Paschke sons ADDRESS Hyattsville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

11-10-61
S. A. D. 11-10-61

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *245*

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince Georges Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>4106 Oglethorpe Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Hyattsville Md.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Barbara</u> (Middle) (Last) <u>Johnson</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>1/14/1870</u>
9. AGE last birthday <u>81 years</u>		10. If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mary E. Parlett Hyattsville Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Myocardial infarction

Antecedent cause(s)

942 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Coronary artery sclerosis

INTERVAL BETWEEN ONSET AND DEATH

1 hr

2 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-18, 1946, to 1-25, 1951, that I last saw the deceased alive on 1-25-51, 1951, and that death occurred at 2:10 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	LOCATION (City, town, or county) <u>Colmar Manor Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Jan 27, 1951</u>	REGISTRAR'S SIGNATURE <u>James Severy</u>	24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville Md.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 234

1. PLACE OF DEATH- COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Piscataway</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Piscataway</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In a field near the village</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u>	(Middle)	(Last) <u>Johnson</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1895</u>
		9. AGE last birthday <u>55</u> yrs.	4. DATE OF DEATH (Month) <u>1</u> (Day) <u>24</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
		17. INFORMANT <u>Rosie McKee</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>932.1</u> Immediate cause (a) <u>Exposure</u> <u>190</u> Antecedent cause(s) (b) <u>Slept out in the cold all night.</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Farm</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Piscataway</u> <u>P. G.</u> <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF <u>Foundry</u> <u>1</u> <u>24</u> <u>51</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Slept out in a woods</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>James D. Boyer</u> M. D.		DATE SIGNED <u>1/24/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>1/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Waldorf</u>	LOCATION (City, town, or county) (State) <u>Waldorf</u> <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1-26-51</u>	REGISTRAR'S SIGNATURE <u>M. L. Howard</u>	24. FUNERAL DIRECTOR <u>Smith & Ryan</u>	ADDRESS <u>Waldorf</u>

Mrs. Alton Davis

820105 md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *7/5*

1. PLACE OF DEATH: COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Lewisdale</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Lewisdale Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>2114 Beechwood Road</i> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Walter</i>	(Middle) <i>Scott</i>	(Last) <i>Jones</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>6/7/1878</i>
9. AGE last birthday <i>72</i> yrs.		10. DATE OF DEATH <i>Jan 5, 1951</i>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Insurance Agent</i>	
12. FATHER'S NAME <i>William Jones</i>		13. MOTHER'S MAIDEN NAME <i>Amelia Owens</i>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		15. SOCIAL SECURITY No.	
16. INFORMANT AND ADDRESS <i>Albert S. Jones Lewisdale Md.</i>		17. CITIZEN OF WHAT COUNTRY? <i>USA</i>	

18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <i>Hypostatic Pneumonia</i>		<i>3 days</i>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Chronic Heart failure</i>		<i>1 week</i>
(c) <i>Arteriosclerotic Cardio-vascular disease</i>		<i>years</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Osteoporosis with compression fracture of 9th vertebra</i>		<i>years</i>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Oct*, 19*49*, to *Jan 5*, 19*51*, that I last saw the deceased alive on *Jan 3*, 19*51*, and that death occurred at *1:30 p.m.*, from the causes and on the date stated above.

SIGNATURE *Ronald S. Fletcher* ADDRESS *5432 Queens Chapel Rd Hyattsville Md* DATE SIGNED *1/5/51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Transportation</i>	<i>1/6/50</i>	<i>Mt Sterling</i>	<i>Kentucky</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>Jan 6, 1951</i>	<i>James Servey</i>	<i>F. Gasch's Sons</i>	<i>Hyattsville Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

450736

RECEIVED
JUN 8 1961
READ V. P.

RECEIVED
JUN 8 1961
READ V. P.

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>University Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>University Park</u>	
TOWN <u>University Park</u>		TOWN <u>University Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4314 Colesville Road</u>		STREET ADDRESS (If rural, give location) <u>4314 Colesville Road</u>	
3. NAME OF DECEASED (First) <u>Alice</u> (Middle) <u>Holmead</u> (Last) <u>O'Dwyer Keegan</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>14th</u> (Year) <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 14th, 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year Months. <u> </u> 1 year Days <u> </u> If under 24 hrs. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Holmead</u>		14. MOTHER'S MAIDEN NAME <u>Alice Unkle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Bryan K.O'Dwyer 227 East Mason Ave., Alexandria, Va.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause Antecedent cause(s) 93d Diseases or conditions, if any, giving rise to the above cause stating the <u>underlying cause last</u>		(a) <u>Right & Left Heart Failure</u> (b) <u>Coronary occlusion</u> (c) <u>Hypertensive Heart Disease</u>		ONSET AND DEATH <u>1 year</u> <u>1 year 3 mo.</u> <u>10 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION _____		
21. ACCIDENT SUICIDE HOMICIDE <u>NONE</u>		(Specify) PLACE (Home, farm, factory, street, office bldg., etc.) _____		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
(CITY OR TOWN) _____		(COUNTY) _____		
(STATE) _____		_____		
TIME (Month) (Day) (Year) OF INJURY		(Hour) INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 1/13, 1950, to 1/14, 1951, that I last saw the deceased alive on 1/14, 1951, and that death occurred at 12:40 P.m., from the causes and on the date stated above.

SIGNATURE _____ (Degree or title) _____ ADDRESS _____

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. **BURIAL, CREMATION
REMOVAL (Specify)**

DATE _____

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)	
----------------------------------	--

7 (State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS _____

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	JAN. 17/1951	ROCK CREEK CEM.	WASHINGTON, D.C.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
JAN 15 1951	Mrs. J. S. Severe, Deputy Social	W.W. Chambers Company,	Riverdale, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 157542

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>	
TOWN <u>Hillside</u>		TOWN <u>Hillside</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>X X X</u>		STREET ADDRESS (If rural, give location) <u>5110 - M st.</u>	
3. NAME OF DECEASED (First) <u>MARTHA</u> (Middle) <u>ANN</u> (Last) <u>KINAHAN</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>4/19/1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Simon McCallough</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Shields</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Daughter in law Mrs. Eloise Kinahan 5110 - M st.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Immediate cause	(a) <u>Broncho pneumonia</u>		
450.0 Antecedent cause(s)	(b) <u>Senility</u>		
107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Generalized arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY	m.		

22. I hereby certify that I attended the deceased from 10 Jan, 1951, to 14 Jan, 1951, that I last saw the deceased alive on 13 Jan, 1951, and that death occurred at 3:05 p m., from the causes and on the date stated above.

SIGNATURE <u>William B. Yowell M.D.</u>	ADDRESS <u>2353-24th St. S.E.</u>	DATE SIGNED <u>14 Jan 51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>11/1/1951</u>	NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG <u>Jan. 15-51</u>	REGISTRAR'S SIGNATURE <u>Carric F. Campbell</u>	24. FUNERAL DIRECTOR <u>W. H. Chambers Co</u> ADDRESS <u>517-11th St S.E.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *0776* *nfs*

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hyattsville</u> LENGTH OF STAY (in this place) <u>2 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mother Jones Rest Home Riggs Road Extended</u>		STREET ADDRESS (If rural, give location) <u># 1 Lauer Terrace</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JOHN</u> (Middle) <u>McCHESNEY</u> (Last) <u>KING</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 14th, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 28/1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	9. AGE last birthday <u>86</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>John King</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Anna McChesney</u>		14. MOTHER'S MAIDEN NAME <u>Anna McChesney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Ida M. Wade, 1 Lauer Terrace, Sil. Sp. Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
331x Immediate cause (a) <u>Cerebral hemorrhage</u>			<u>Jan 9, 51</u>
Antecedent cause(s)			
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

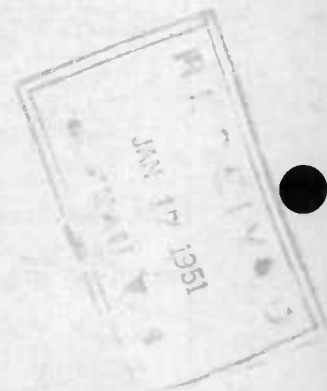
22. I hereby certify that I attended the deceased from <u>Jan 50</u> , 19 <u>50</u> , to <u>Jan 51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>51</u> , and that death occurred at <u>10:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>John N. Andrews M.D.</u>		ADDRESS <u>960 Colleso Rd. Silver Spring</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Jan. 17/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>
LOCATION (City, town, or county) <u>Suitland, Pr. Geo. Cty. Md.</u>		(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 15 1951</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severo</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Company</u>		ADDRESS <u>Riverdale, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

583888



0777

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ritchie</u> LENGTH OF STAY (in this place) <u>1 month</u> TOWN <u>Ritchie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Healey's Farm</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pennsylvania</u> COUNTY <u>Spangler</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spangler</u> OR TOWN <u>Spangler</u> STREET ADDRESS <u>Box 605 Crawford Grove</u>	
3. NAME OF DECEASED (First) <u>Gregory</u> (Middle) <u>D</u> (Last) <u>Kirsch</u> (Type or Print)		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>single</u>	8. DATE OF BIRTH <u>2-12-30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sergeant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Airforce</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Laurence Kirsch</u>		14. MOTHER'S MAIDEN NAME <u>Anna</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Aug 1948</u>		16. SOCIAL SECURITY NO. <u>U.S. Airforce Records</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, or other bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY 1 28 51 3

INJURY OCCURRED
 While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-28-51

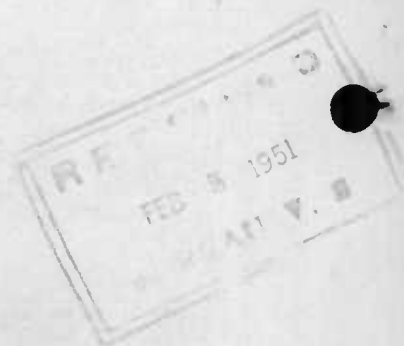
Alma R. Hall

Walter Funeral Home
301 E. Capitol St. Wash. D.C.
595916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 231

1. PLACE OF DEATH- COUNTY <u>Prince George's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> TOWN <u>Cherry</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2904 Tremont Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince George's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> TOWN <u>Cherry</u> STREET ADDRESS <u>2904 Tremont Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>George Edward Song</u>		4. DATE OF DEATH <u>Jan 17 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 29, 1873</u>
9. AGE last birthday <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Building Contractor</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Stone-cutter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Song</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Edith Mae Griffith - Daughter</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Acute congestive heart failure</u> Antecedent cause(s) (b) <u>Coronary atherosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>John J. Maloney, M.D., Dep. Med. Exam.</u>		DATE SIGNED <u>1-17-51</u>	
3. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>Jan 19, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Southland, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1/18/51</u>		REGISTRAR'S SIGNATURE <u>Amanda Dorney</u>	
24. FUNERAL DIRECTOR <u>Joseph S. Hyattsville, Md.</u>		ADDRESS <u>584 246</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
 City or town Washington 19 DC
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs
 Hospital, institution, or street address where death occurred:
6509 Marlboro Rd. SE
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Washington 19 DC
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6509 Marlboro Rd SE.
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Dominick Magnolia

3. (b) Social Security Number

579-01-6028

4. Sex M 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Nancy Traboss
Magnolia 6. (c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) Dec 29 1885
 8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Italy
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Retired
 12. Name Joe Magnolia
 13. Birthplace Italy
 14. Maiden name Katherine Marcelle
 15. Birthplace Italy

16. Informant Nancy Magnolia
 Address 6509- Marlboro Road SE
 17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan 23 1957
 (month) (day) (year)
 Cemetery or crematory Edgar Hill Cemetery
 Location Switzland Maryland

18. Funeral director William Dees Sons Co.
 Address 300- 4th St NE, Wash. DC
 19. Jan 22 1957 Edna F. Solberg
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1957 at 4:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1950 to Jan 21 1957
 and that I last saw him alive on Jan 20 1957
 Immediate cause of death Coronary
hypertrophic of liver 6 M.O.
with metastasis
 Due to 561.0
124.5
 Other conditions General Arterio-
sclerosis unknown
 (Include pregnancy within 3 months of death)
 Major findings of operations none
 Date of op. _____

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Natural Cause
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Van Yatta
5440 Silver Age Road M. D. 1957
 Address Washington 19 DC Date signed Jan 21
970/VVV

14

1661-20-1051
JUN 28 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges
 City or town 6858 Allentown Rd SE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)
 State Maryland County Prince Georges
 City or town Washington 20 D C
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6858 Allentown Rd, SE.
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

FLORENCE ELLEN MARDEN

3. (b) Social Security Number

none

4. Sex FEMALE 5. Color or race white 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 28th 1863 6.(c) If alive, give age 87 years

8. AGE: Years 87 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Allentown, Maryland
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

MOTHER FATHER 12. Name Henry F. Marden

13. Birthplace Maryland

14. Maiden name Leonora Sherriff

15. Birthplace Maryland

16. Informant Clyde W. Shreve

Address 6858 Allentown Rd SE

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 17-1951
 (month) (day) (year)

Cemetery or crematory St Barnabas Cemetery

Location Oxon Hill, Maryland

18. Funeral director Simmons Brothers

Address 2007-Nichols Ave S E

19. Date rec'd by registrar Jan 15 1951 Registrar Mrs. Alton Davis

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1951 at 8:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1951 to Jan 13 1951
 and that I last saw her alive on Jan 14 1951

Immediate cause of death Cerebral Hemorrhage

(Paralysis of Left Side of Body)
 Due to Small Arterio Sclerosis

Due to none of note

Other conditions 331x

(Include pregnancy within 3 months of death)

Major findings of operations 830w

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Natural Cause

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Van Gatta

Address Washington 19 DC Date signed Jan 15 1951

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH - COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Springfield Md		CITY (If outside corporate limits, write RURAL and give nearest town) Springfield Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) Springfield Road	
3. NAME OF DECEASED (Type or Print) (First) George (Middle) Thomas (Last) Markwood / MARKWARD		4. DATE OF DEATH (Month) Jan (Day) 30, (Year) 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married	8. DATE OF BIRTH 4/21/1883
9. AGE last birthday 67 yrs.		10. If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - owner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George A Markwood MARKWARD		14. MOTHER'S MAIDEN NAME Bell Butchinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs Rose V Markwood Springfield Md.			
18. MEDICAL CERTIFICATION Markwood			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary occlusion			6 hrs.
Antecedent cause(s) (b) Carcinoma of prostate			2 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
22. TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?			
23. I hereby certify that I attended the deceased from 10/8, 1949, to 1/30, 1951, that I last saw the deceased alive on 1/30, 1951, and that death occurred at 6:35 A.M., from the causes and on the date stated above.			
SIGNATURE Frederick E. Munner M.D., 7409 Varnum St.		DATE SIGNED 1/30/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 2/1/51	
NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		LOCATION (City, town, or county) Colmar Manor Md.	
DATE REC'D BY LOCAL REG. 1/31/51		24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.	
REGISTRAR'S SIGNATURE Mrs. A. H. Gierling		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change
in 13 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0782

FUM No. G 131 MAR 28 1951 **CERTIFICATE OF DEATH**

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chesley</u> TOWN <u>13 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> TOWN <u>Bowie</u> STREET ADDRESS (If rural, give location) <u>-</u>	
3. NAME OF DECEASED (Type or Print) <u>Joseph</u> (First) <u>St.</u> (Middle) <u>Ma</u> (Last)	4. DATE OF DEATH <u>Jan</u> (Month) <u>14</u> (Day) <u>1951</u> (Year)	5. SEX <u>m</u> 6. COLOR OR RACE <u>w</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m</u> 8. DATE OF BIRTH <u>July 30, 1904</u> 9. AGE last birthday <u>46</u> yrs. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Carson Mast</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Louise M. Mast</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>877-12-9616</u> 17. INFORMANT AND ADDRESS <u>Mrs. Louise M. Mast Bowie Md</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) T.B. on lung

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) T.B. on lung

Post-mortem examination showed:

(c) 1.) Diffuse Encephalo-Myelitis

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

2.) Multiple Septic abscesses of Lung

3.) No T.B. (3/28/51 aka)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1951, to Jan 14, 1951, that I last saw the deceased alive on Jan 14, 1951, and that death occurred at 3:40 P. m., from the causes and on the date stated above.

SIGNATURE Albert R. Roll

(Degree or title)

ADDRESS Reverdale, Pa

DATE SIGNED 1-15-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF Jan 17 1951

NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery

LOCATION (City, town, or county) Colmar Manor Md

(State)

DATE REC'D BY LOCAL REG. Jan 16/51

REGISTRAR'S SIGNATURE Amanda Downey

24. FUNERAL DIRECTOR E. Paschos

ADDRESS Hyattsville Md

043246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0783

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>PG</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Friendly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Friendly</u>	
TOWN <u>Friendly</u>		TOWN <u>Friendly</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8320 Old Fort Road</u>		STREET ADDRESS (If rural give location) <u>8320 Old Fort Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Juanita</u> (Middle) <u>Medley</u> (Last) <u>Medley</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>6</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u>	8. DATE OF BIRTH <u>6-8-50</u>
9. AGE last birthday <u>6 mos</u>		10. If under 1 year Months <u>6</u> Days <u>1</u> Hours <u>6</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Theodore Medley</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Washington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5</u>	
17. INFORMANT <u>Rosalie Medley</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Tuberculosis</u>		
Antecedent cause(s) (b) <u>Broncho pneumonia</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) James J. Boyd M.D. ADDRESS Forestville Md DATE SIGNED 1-6-57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/7/50</u>	NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	LOCATION (City, town, or county) (State) <u>Piscataway Md.</u>
DATE REC'D BY LOCAL REG. <u>1/6/50</u>	REGISTRAR'S SIGNATURE <u>Mrs. Aston Davis</u>	FUNERAL DIRECTOR <u>Huntt & Ryan</u>	ADDRESS <u>Waldorf Md.</u>

[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2245

1. PLACE OF DEATH - COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HYATTSTVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>4631 42nd Place</u> (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Sadie Alice Messick</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 18 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 1, 1905</u>
9. AGE last birthday <u>45 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>G. C. Vaughn</u>		14. MOTHER'S MAIDEN NAME <u>Sally Vaughn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Douglas T. Messick Same as # 2</u>		18. MEDICAL CERTIFICATION <u>Hyattsville Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Tuberculous renal abscess8 mo.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8-3, 1949, to 1-18, 1951, that I last saw the deceased alive on 1-14, 1951, and that death occurred at 5:10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-19-51</u>	NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>
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DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 18, 1951 James SeveyA. Gasch, SonsHyattsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *245*

1. PLACE OF DEATH - COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Washington</i> COUNTY <i>D.C.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
TOWN <i>Hyattsville</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hyattsville Conv. Cent Home</i>		STREET ADDRESS (If rural, give location) <i>5132 7th St. NW</i>	
3. NAME OF DECEASED (Type or Print) <i>PHOEBE JANE METZGER</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Jan. 8 1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Dec 2, 1870</i>
9. AGE last birthday <i>80</i> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel B. Burke</i>		14. MOTHER'S MARRIED NAME <i>Phoebe J. Metzger</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No. <i>—</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Andrew W. W. 5132 7th St. NW Wash. D.C.</i>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Longstanding heart failure*

Antecedent cause(s)

(b) *Hypertension and hypertensive heart disease*(c) *Senility*

INTERVAL BETWEEN ONSET AND DEATH

*6 mo.**10 yrs +*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

*Carcinoma of right breast**2 yrs.*

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/15*, 19*49*, to *1/8*, 19*51*, that I last saw the deceasedalive on *1/8*, 19*51*, and that death occurred at *8:15 P.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

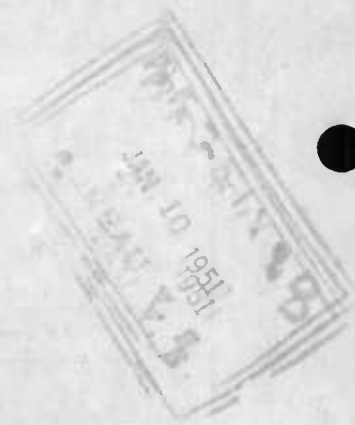
ADDRESS

*Jan 8, 1951 James Sever**Wm. Chambers, Jr. 1410 Chapin St. NW**Wash. D.C.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



Evidence for change
in 17 & 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0786

FILE No. G 130 FEB 14 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
City or town Farmount Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
City or town Farmount Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5807 Sheriff Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Jane Mizell

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Negro Widowed

6.(b) Name of husband or wife

Ross Mizell

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years

April 9, 1853

8. AGE: Years Months Days If less than one day
97 9 17 hrs. min.

9. Birthplace Robersonville, N.C.
(Town, county, and state)

10. Usual occupation Farm

11. Industry or business none

12. Name Harry Clark

13. Birthplace Robersonville, N.C.

14. Maiden name Eliza ?

15. Birthplace

16. Informant Mrs. Odie Kelliebrew

Address 5807 Sheriff Rd.

17. Burial Date thereof (month) (day) (year)

Cemetery or crematory Westville, N.C.

Location Washington, D.C.

18. Funeral director Robert J. Campbell

Address 423 4th St. NW

19. 1/26 1951 Anna de Dour

(Date rec'd by registrar) Carrie J. Campbell

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1951 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on

Aug. 1947 to Jan. 26 1951

and that I last saw her alive on Jan. 24 1951

Immediate cause of death Congestive Heart Failure

Due to Natural Causes

Other conditions Senility

4341 (Include pregnancy within 8 months of death)

932

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John W. Robinson, M.D.

Address 1001 Eastern Ave. N.E.

Date signed 1-26-51

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ²⁸¹ 214

1. PLACE OF DEATH. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u> COUNTY <u>Pr. Geor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arundel, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Gen. Hosp</u>		STREET ADDRESS (If rural, give location) <u>4308 Kaywood Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Clamonts</u>	(Middle)	(Last) <u>Myers</u>
6. SEX <u>M</u>	5. COLOR OR RACE <u>M</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Jan 27, 1884</u>
9. AGE last birthday <u>66</u> yrs.		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>12</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Retired, freight rate, Baltimore and Annapolis</u>		<u>Georgia</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Georgia</u>		<u>Unknown</u>	
13. FATHER'S NAME <u>Greenberry Myers</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>No</u>		<u>4308 Kaywood Dr</u>	
17. INFORMANT AND ADDRESS <u>Mrs Eva Myers Wif. Mt Rainier</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Uremia</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Antecedent cause(s) (b) <u>Chronic Glomerular Nephritis</u>	<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive Heart Disease</u>	<u>2 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchopneumonia</u>	<u>4 days.</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1950, to Jan 12, 1951, that I last saw the deceased alive on Jan 12, 1951, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

SIGNATURE Samuel D. Sugar (Degree or title) M.D. ADDRESS 4308 Kaywood Drive Mt Rainier, Md DATE SIGNED Jan 12, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Elmo Cemetery</u>	LOCATION (City, town, or county) (State) <u>Forest Hill Tenn</u>
DATE REC'D BY LOCAL REG <u>1/15/51</u>	REGISTRAR'S SIGNATURE <u>Amarda Wonne</u>	24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>	ADDRESS <u>2901-14 St. N.W.</u>

390807

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE'S</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
TOWN <u>Oxon Hill</u>		TOWN <u>Oxon Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>5100 LIVINGSTON RD.</u>	
3. NAME OF DECEASED (First) <u>MARY ELIZABETH</u> (Middle) <u>OWENS</u> (Last) <u>OWENS</u>		4. DATE OF DEATH (Month) <u>JANUARY</u> (Day) <u>19</u> (Year) <u>1950</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>2 OCT. 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>JAMES L. McQUADE</u>		11. BIRTHPLACE (State or foreign country) <u>ST. MARY'S Co. MD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY No. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>MARY PILKERTON</u>	
17. INFORMANT AND ADDRESS <u>LANCASTER OWENS, Oxon Hill MD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>			<u>9 days</u>
Antecedent cause(s) (b) <u>Arteriosclerosis + Hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>		INJURY OCCURRED While at <u>Work</u> Not While <u>At work</u>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec 5, 1950, to Jan 19, 1951, that I last saw the deceased alive on Jan 19, 1951, and that death occurred at 8 25 P.m., from the causes and on the date stated above.

SIGNATURE Max E. Feldman MD ADDRESS 3800 S. Capitol St. Wash. DC. DATE SIGNED Jan 19, 1951

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE 23-JAN-1951 NAME OF CEMETERY OR CREMATORY CEDAR HILL LOCATION (City, town, or county) SUITLAND, MD (State) MD

DATE REC'D BY LOCAL REG. Jan. 20-51 REGISTRAR'S SIGNATURE Carrie F. Campbell 24. FUNERAL DIRECTOR W. W. CHAMBERS CO ADDRESS WASH DC

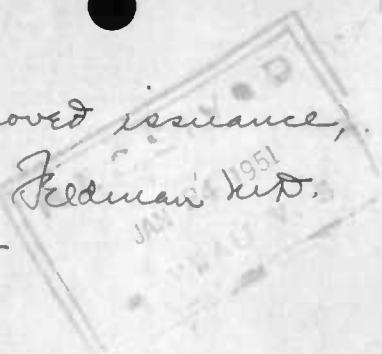
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Boyd, Coroner, notified + has approved issuance,
of certificate.

Max E. Friedman M.D.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0789 231

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Prince Georges Gen. Hosp.</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>903 Pershing Drive</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Leo</u> (Middle) <u>J.</u> (Last) <u>Paquette</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Sept. 16, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard - Washington Suburban Sanitary Comm</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Paul Paquette</u>		14. MOTHER'S MAIDEN NAME <u>Rose Lee Saganette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>281-24-8528</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Honora Paquette</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>12:30:50</u>
Immediate cause (a) <u>Cerebral Accidents</u>		
Antecedent cause(s) (b) <u>33/X 83a Puerperal Endotoxemia</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-30, 1951, to 1-30, 1951, that I last saw the deceased alive on 1-30, 1951, and that death occurred at 3:10 A.M., from the causes and on the date stated above.

SIGNATURE <u>Leo J. Paquette</u> (Degree or title)		ADDRESS <u>Hagerdale, Md.</u>		DATE SIGNED <u>1-31-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 3, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	LOCATION (City, town, or county) <u>Forest Glen, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2/5/51</u>	REGISTRAR'S SIGNATURE <u>Amanda Dourney</u>	24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>	ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

763 597



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 275

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Washington D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eugene Leland Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>1322 Ingraham St., N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Christina</u> (First) <u>Pfloger</u> (Last)		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 23, 1859</u>
9. AGE last birthday <u>91</u> yrs.		10. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. FATHER'S NAME <u>Garlem Frederick William</u>		13. MOTHER'S MAIDEN NAME <u>Elizabeth Anna Arlens</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		15. SOCIAL SECURITY NO. <u>None</u>	
16. INFORMANT AND ADDRESS <u>Mrs. Helen Schlegel - 1322 Ingraham St., N.W.</u>		17. MEDICAL CERTIFICATION <u>Washington, D.C.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 Immediate cause (a) Bronchitis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

106c

(b) General arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 weeks
undeter-
mined

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

18a. DATE OF OPERATION		18b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF		While at			
INJURY		Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from Jan. 17, 1951, to Jan. 28, 1951, that I last saw the deceasedalive on Jan 28, 1951, and that death occurred at 2:50 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
		<u>1-30-51</u>		<u>Rack Creek Bur</u>		<u>Washington D.C.</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>Jan 28, 1951</u>		<u>James Serey</u>		<u>Deaf Funeral Home</u>		<u>4812 Ga Ave NW</u>		<u>D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

illegible

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JAN 30 1961
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U.S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

245

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P. g</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glass Manor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glass Manor</u>	
TOWN <u>Glass Manor</u>		TOWN <u>Glass Manor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>318 - Audrey Lane</u>		STREET ADDRESS (If rural, give location) <u>318 Audrey Lane</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Alexander</u> (Middle) <u>Lloyd</u> (Last) <u>Pickers</u>		(Month) <u>1</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Aug 2, 1916</u>
9. AGE last birthday <u>34</u> yrs.		10. If under 1 year Months <u>1</u> Days <u>3</u> Hours <u>19</u> Min. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Airplane</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alexander Pickers</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Tobin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No. <u>362-12-3724</u>	
17. INFORMANT <u>Lloyd H. Tobin</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

asphyxia

Antecedent cause(s)

(b)

hanging

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office, etc.) OF INJURY Home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Jan 1 3 51 900 PMINJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Hanged self

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

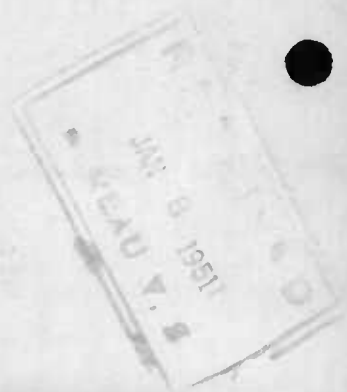
ADDRESS

Jan 6 1951James SeverF. RaschisoneForestville Md1-3-51

515 377

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0793

Reg. Dist. No. 142

1. PLACE OF DEATH COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fairmont Heights Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fairmont Heights Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS --		STREET ADDRESS (If rural, give location) <u>5907 Sheriff Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Grace Louise Pollard</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 23, 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 6, 1915</u>
9. AGE last birthday <u>35 years</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Spencerville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>George Bond</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>James Pollard Fairmont Heights Maryland</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Congestive heart failure</u> Antecedent cause(s) (b) <u>Zepheria of</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pregnancy</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/26/51</u>	<u>Paynes</u>	<u>Benning Rd. Wash. D.C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Jan. 24-51</u>	<u>Carrie F. Campbell</u>	<u>Wynette K. Rollins</u>	<u>4339 Hunt Ph. 9-2</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0792 245

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince George	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville R.R. 1		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville R.R. 1 Box 1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2900 Blk. of Nicholson St.		STREET ADDRESS (If rural, give location) 2900 Blk of Nicholson St.	
3. NAME OF DECEASED (Type or Print) (First) Willette (Middle) M. (Last) Poole		4. DATE OF DEATH (Month) Jan 18, 1951 (Day) 19 (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH Sept 3, 1883
9. AGE last birthday 67 Yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bank Clerk		10b. KIND OF BUSINESS OR INDUSTRY The Merk. T. of Balto.	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME ? Poole		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs Grace Augherton		Same as # 1 & 2	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive & arteriosclerotic heart disease

10 years

(c) Cerebral Thrombosis (old)

7 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hemiplegia (old) Left Side.

7 months

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-2, 1950, to 1-6, 1951, that I last saw the deceased

alive on 1-6-50, 1951, and that death occurred at 7:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William Frank

M.D.

5850 ager Road

1/18/51

23. BURIAL, CREMATION REMOVAL (Specify)

Burial

DATE THEREOF

Jan 22, 1951

NAME OF CEMETERY OR CREMATORY

St Marys Cemetery

LOCATION (City, town, or county)

Washington, D.C.

(State)

DATE REC'D BY LOCAL REG.

Jan 19, 1951

REGISTRAR'S SIGNATURE

James Leroy

24. FUNERAL DIRECTOR

F. Gasch's Sons

ADDRESS

Hyattsville, Md.

290716

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in #8 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FILM No. G 130 JAN 16 1951 FOR MEDICAL EXAMINERS

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P.R.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Agassess</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Agassess</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 year</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Julius</u>	(Middle) <u>Peter</u>	(Last) <u>Reeder</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dr. J. Fort</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Peter Reeder</u>		14. MOTHER'S MAIDEN NAME <u>Nellie V. Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>Ernest Reeder</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>congestive heart failure</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Cardiovascular renal disease</u>	
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>James D. Boyd M.D.</u>		ADDRESS <u>Freestates Md</u>		DATE SIGNED <u>1-4-51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>1/8/51</u>	<u>WOODLAWN</u>	<u>WASHINGTON, D.C.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 5, 1951</u>	<u>Carrie F. Campbell</u>	<u>Robert H. Quinn</u>	<u>1820-9 St. NW, Wash, D.C.</u>	

9537

970916

1820-9 St. NW, Wash, D.C.

RECEIVED
JAN 8 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0795

Reg. Dist. No.

local 240
COUNTY P. 30

1. PLACE OF DEATH COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Naylor MD		CITY (If outside corporate limits, write RURAL and give nearest town) Naylor MD	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Charles	(Middle) Henry	(Last) Richards
4. DATE OF DEATH	(Month) 1	(Day) 5	(Year) 1957
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 3-23-1886
9. AGE last birthday 64 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Richards		14. MOTHER'S MAIDEN NAME Margaret Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Harold Richards (son)	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Vremia		4 days
Antecedent cause(s) (b)	Chr pyelonephritis		2 mos
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	Chr prostatic hypertrophy		Unk
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
Hypertension, chr cardiac failure			2 yrs
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug., 1950, to 5 Jan., 1957, that I last saw the deceased alive on 5 Jan., 1957, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 1-8-57	NAME OF CEMETERY OR CREMATORY Oakland	LOCATION (City, town, or county) Waldorf	(State) MD
DATE REC'D BY LOCAL REG. 1-6-57	REGISTRAR'S SIGNATURE M. B. Moore	24. FUNERAL DIRECTOR		ADDRESS
1-9-1957	F. A. Billingsley (local)	Hunt & Ryan		Waldorf MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0796
Reg. Dist. No. 231

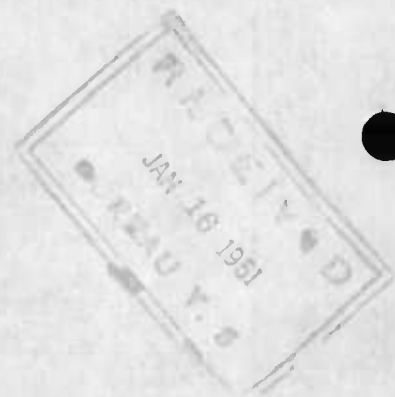
1. PLACE OF DEATH- COUNTY Prince George's CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cheverly Md HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince George's CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville Md. STREET ADDRESS (If rural, give location) 4326 Farragut St	
3. NAME OF DECEASED (First) John (Middle) W alter (Last) Richards	4. DATE OF DEATH Jan 11, 1951		5. SEX male
6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 2/23/1884	9. AGE last birthday 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Sanitary Grocery Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Leonard Richards		14. MOTHER'S MAIDEN NAME Estelle Dixon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Kathryn Caldwell		Patuxent River Md.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) Acute Coronary Occlusion Antecedent cause(s) (b) Chronic Coronary Insufficiency Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 420,1 94a			INTERVAL BETWEEN ONSET AND DEATH
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-4, 1940, to 1-11-51, that I last saw the deceased alive on 1-11-51, and that death occurred at 11:55 P.m., from the causes and on the date stated above.			
SIGNATURE Ce. D. D. D.		ADDRESS Hyattsville Md.	
DATE SIGNED 1-15-51			
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1/15/51	
NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		LOCATION (City, town, or county) Washington D. C.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville Md.	

290636

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Prince Geo's</u>	
CITY (If outside corporate limits, write RURAL, and OR give nearest town) <u>Berwyn, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BERWYN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's Gen. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>5002 Huron St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Betty Linda Jane</u> (First) <u>Richardson</u> (Middle) <u>May</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>January 11, 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Jan. 10, 1951</u>
9. AGE last birthday <u>13</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Infant</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Cheverly, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Richardson, Thomas E.</u>		14. MOTHER'S MAIDEN NAME <u>May, Betty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give date of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Thomas E. Richardson - 5002 Huron St. Berwyn Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
2.76x, Immediate cause (a) <u>Prematurity</u>		
Antecedent cause(s) (b) <u>159</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 4, 1951, to Jan 11, 1951, that I last saw the deceased alive on Jan 11, 1951, and that death occurred at 4:30 P m., from the causes and on the date stated above.

SIGNATURE Howard Woodall M.D. ADDRESS 30-B Bridge Rd. Greenbelt, Md DATE SIGNED 1-12-51

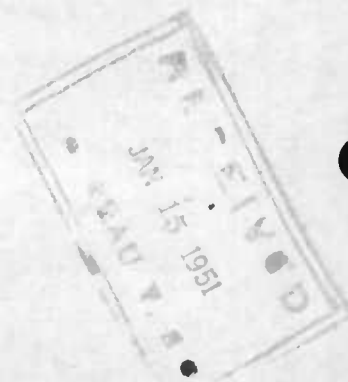
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>1/15/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>	LOCATION (City, town or county) (State) <u>Laurel, Pr. Geo., Md.</u>
DATE REC'D BY LOCAL REG. <u>1-13-51</u>	REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co. - Riverdale, Md</u>	ADDRESS

20111161301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

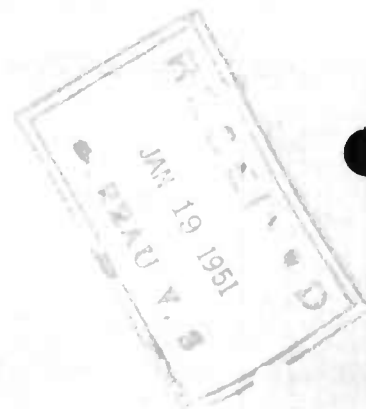
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>Prince George Co.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>5106 Byers St.</u> TOWN <u>Boulevard Heights</u> LENGTH OF STAY <u>7 Mo</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>5106 Byers St.</u> TOWN <u>Boulevard Heights</u> STREET ADDRESS <u>5106 Byers St.</u> (If rural, give location)									
3. NAME OF DECEASED (Type or Print) <u>ANNE</u> (First) <u>MATILDA</u> (Middle) <u>RILEY</u> (Last)		4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>51</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>		8. DATE OF BIRTH Month <u>May</u> Day <u>12</u> Year <u>1866.84</u> yrs.		9. AGE last birthday If under 1 year: Months <u>8</u> Days <u>1</u> If under 24 hrs: Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>				11. BIRTHPLACE (State or foreign country) <u>Louden Co. Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Henry Reed</u>				14. MOTHER'S MAIDEN NAME <u>Susan R Nicols</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					
16. SOCIAL SECURITY No.				17. INFORMANT <u>5106 Byers St</u> <u>Mrs John Phillips. Boulevard Hts</u>									
18. MEDICAL CERTIFICATION													
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										INTERVAL BETWEEN ONSET AND DEATH			
260x Immediate cause (a) <u>CORONARY THROMBOSIS</u>										<u>Auto</u>			
61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>CORONARY HEART DISEASE + SCLEROSIS</u>										<u>2 years</u>			
(c) <u>DIABETES MELITUS</u>										<u>3 years</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.													
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?									
22. I hereby certify that I attended the deceased from <u>MARCH</u>, 19 <u>49</u> ., to <u>JANUARY 13</u> 19 <u>51</u> ., that I last saw the deceased alive on <u>JAN. 12</u>, 19 <u>51</u> ., and that death occurred at <u>7:00 A. m.</u> , from the causes and on the date stated above.													
SIGNATURE <u>Ernest C. Cornelson M.D.</u>				ADDRESS <u>4400 Bowen Pl. SE. Wash 19, D.C.</u>				DATE SIGNED <u>1/13/51</u>					
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)					
<u>Burial</u>		<u>Jan 16/51</u>		<u>Forest Oak</u>		<u>Gaithersburg, Md.</u>							
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS							
<u>Jan. 16. 51</u>		<u>Carrie E. Campbell.</u>		<u>Ernest C. Gartner</u>		<u>Md.</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *246*

1. PLACE OF DEATH- COUNTY Prince Georges Co MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince Georges Co	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Brentwood Md.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Brentwood Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS --		STREET ADDRESS (If rural, give location) 4008 Sheppard Street.	
3. NAME OF DECEASED (Type or Print) (First) Everett (Middle) Hiram (Last) Roberts		4. DATE OF DEATH (Month) (Day) (Year) Jan 23, 1951- 19	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 8/29/1863
9. AGE last birthday 87 years		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer	
11. BIRTHPLACE (State or foreign country) Albany New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Abraham H. Roberts		14. MOTHER'S MAIDEN NAME Elizabeth Tite.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT AND ADDRESS Marguerite R. Miller Brentwood Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) Apoplexy

93d Antecedent cause(s) Cardio-vascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Senile

INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hr

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
SUICIDE
HOMICIDE
INJURYTIME (Month) (Day) (Year) (Hour) INJURY OCCURRED
OF While at Not While
INJURY m. Work At work

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from *6/15*, 19*69*, to *1/23*, 1951, that I last saw the deceased alive on *1/23*, 1951, and that death occurred at *7:30 P.* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial *1/27/51* *St. Lincolns Cemetery* *Colmar Manor Md*

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

512 916

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>326 - A. St., N.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>PALMIR</u> (First) (Middle) (Last) <u>Rossi</u>		4. DATE OF DEATH <u>JAN 24</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-4-87</u>
9. AGE last birthday <u>63</u> yrs.		10. If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Granite cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Rossi</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Garbin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>243-03-5581</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis

Antecedent cause(s) (b) Emphysema

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION Silicosis

21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 9-7-, 1950, to 1-24-, 1951, that I last saw the deceased

alive on 1-24-, 1951, and that death occurred at 2:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

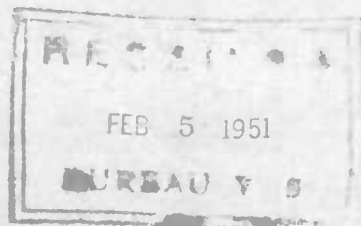
Daniel Leo Pinicane M.D. Glenn Dale Sanatorium 1/24/51
Glenn Dale, Md.

23. BURIAL CREMATION REMOVAL (Specify) <u>removal</u>	DATE THEREOF <u>1-24-51</u>	NAME OF CEMETERY OR CREMATORY <u>Washington</u>	LOCATION (City, town, or county) (State) <u>D.C.</u>
DATE REC'D BY LOCAL REG. <u>1/25/51</u>	REGISTRAR'S SIGNATURE <u>W. Weiss</u>	24. FUNERAL DIRECTOR <u>584326 300 4th St. Wash. D.C.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 18345

1. PLACE OF DEATH- COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Prince Geo	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Gaithersburg		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Gaithersburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3121- Queens Chapel Rd		STREET ADDRESS (If rural, give location) 3121- Queens Chapel Rd.	
3. NAME OF DECEASED (Type or Print) Mary Gertrude (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) Jan 17 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan 8, 1891
9. AGE last birthday 60 yrs.		10. BIRTHPLACE (State or foreign country) Wash D. C.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT Country U.S.A.	
13. FATHER'S NAME Hurdle		14. MOTHER'S MAIDEN NAME Hannah Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Sally Hurdle			

18. MEDICAL CERTIFICATION 919-4421, N.W. Wash, D.C.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary thrombosis	INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs.
94a Antecedent cause(s) (b) Hypertension	15 yrs.
(c)	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 19 46 to Jan 17, 19 51, that I last saw the deceased alive on Jan 17, 19 51, and that death occurred at 25 P.M., from the causes and on the date stated above.

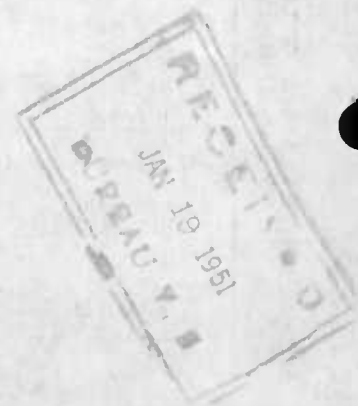
SIGNATURE Richard F. Shaw M.D. 7324 Mich Ave N.E. (D.C.) 1-17-51
(Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-20-51	NAME OF CEMETERY OR CREMATORY St. Lincoln	LOCATION (City, town, or county) (State) Colmar Manor, Md.
DATE REC'D BY LOCAL REG. Jan 27 1951	REGISTRAR'S SIGNATURE Mrs. Jas. Severe (Deputy)	24. FUNERAL DIRECTOR The S. S. Hines Co.	ADDRESS 2901-14th St NW Wash D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 342

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1228-55th Avenue</u>		STREET ADDRESS (If rural give location) <u>1228-55th Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>John</u> (Middle) <u>Edward</u> (Last) <u>Russ</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>3-27-25</u>
9. AGE last birthday <u>25</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Shelton Russ</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Frances Hudley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT <u>Mildred Russ</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.4 Immediate cause

(a) Acute congestive heart failure

1572 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Congenital heart disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/3/51</u>	<u>Eden Hill</u>	<u>Shutland, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan. 3-51</u>	<u>Carrie F. Campbell</u>	<u>W.W. Chambers Co.</u>	<u>517 N. St SE</u>	

690506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges
City or town Ayothville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 wks
Hospital, institution, or street address where death occurred:
3304 Kameer Drive
How long in hospital or institution? 2 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State -- County --
City or town Ciudad Trujello
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dominican Republic
(If rural, give LOCATION)
2.(a) If veteran, name war --

3. (a) FULL NAME

Ricardo Salazar (RICARDO SALAZAR)

3. (b) Social Security Number

None

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced child
6.(b) Name of husband or wife --
7. Birth date of deceased (mo., day, yr.) June 26, 1949 6.(c) If alive, give age -- years
8. AGE: Years 1 Months 6 Days -- If less than one day -- hrs. -- min.

9. Birthplace Ciudad Trujello-Dominican Repb.
(Town, county, and state)

10. Usual occupation None

11. Industry or business Infant

12. Name Juan Salazar
13. Birthplace Dominican Republic
14. Maiden name Margarita Morales
15. Birthplace Dominican Republic

16. Informant Dr. Angel E. Salazar
Address Professional Bld'g. Herndon, Va.

17. Removal Date thereof January 22, 1951
(Burial, cremation, or removal. Which?) (month) (day)
to Ryan Funeral Home
Cemetery or crematory
Location Washington, D.C.

18. Funeral director James T. Ryan, Inc.
Address 317 Penna. Ave., S.E. Washington, DC

19. Jan 22 57 Jean Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1951 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/9 1951, to 1/20 1951, and that I last saw him alive on 1/20 1951.

Immediate cause of death Sepsis from pneumonia DURATION 2 days

Due to Skin infections & internal hemorrhage

Due to Hans Schuller Christian Disease with on

Other conditions 289.0

109 (Include pregnancy within 3 months of death)

Major findings of operations --

Date of op. --

Autopsy results --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Thomas A. Christensen, M.D.

Address College Park Rd Date signed 1/20/51

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D. C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale, (RURAL)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>1430 - V. St., N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>ALFRED</u> (First) <u>SAYLES</u> (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>-</u>	8. DATE OF BIRTH <u>6/15/1910</u>
9. AGE last birthday <u>40</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper on truck</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Sayles</u>		14. MOTHER'S MAIDEN NAME <u>Mary Morton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>578-16-3555</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

11 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/26/, 1950, to 1/19/, 1951, that I last saw the deceased

alive on 1/19/, 1951, and that death occurred at 11:40 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Sanatorium,
Glenn Dale, Maryland

DATE SIGNED

1/19/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>1/19/51</u>	<u>-</u>	<u>-</u>	<u>Fredericksburg - Virginia</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	
<u>1/19/51</u>	<u>W. H. Weiss</u>	<u>D. H. Kay, Fredericksburg, Virginia</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HEIGHTS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HEIGHTS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>122 Ralph Drive</u>		STREET ADDRESS (If rural, give location) <u>122 Ralph Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u>	(Middle)	(Last) <u>SEITZ</u>
4. DATE OF DEATH	(Month) <u>JAN</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/14/1876</u>
9. AGE last birthday <u>74</u> yrs.		10. DATE OF DEATH <u>JAN 4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chicago Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Gustav Seitz</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Schmaltz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>George K. Seitz, 122 Ralph St. Forest Heights Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Cerebro Vascular Accident (apoplexy)</u>		<u>6 hrs.</u>
(b) Antecedent cause(s) <u>ARTERIOSCLEROSIS - Heart Disease & Hypertension</u>		<u>years</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Carcinoma of PROSTATE</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Jan 4, 1951, that I last saw the deceased alive on Jan 4, 1951, and that death occurred at 11:35 p.m., from the causes and on the date stated above.

SIGNATURE Max E. Feldman MD (Degree or title) ADDRESS 2800 S. Capitol St. Wash. D.C. DATE SIGNED 1/5/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1/5/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Beverly Cemetery 120 St.</u>	LOCATION (City, town, or county) <u>Blue Island Ill</u>	(State) <u>Ill</u>
DATE REC'D BY LOCAL REG. <u>Jan. 5, 1951</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>St. St. Chambers Co. 517-11 St. S.E.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290816

J. B.
Mr Boyd, security coroner notified & approves
renewal of this certificate.
~~W E~~ W E Tellman, Secy

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *mf5*

1. PLACE OF DEATH

County *Prince Georges*City or town *6403 Agate Rd. Hyattsville*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *5 mo.*

Hospital, institution, or street address where death occurred:

*6403 Agate Rd. Hyattsville*How long in hospital or institution? *5 mo*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) if veteran, name war.....

3. (a) FULL NAME

Donald P. Shugar

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

child

8. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

September 3, 1949

8. AGE:

Years

Months

Days

If less than one day

*1**5*

hrs.

min.

9. Birthplace.....

Washington, DC
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER
MOTHER

12. Name.....

Lee H. Shugar

13. Birthplace.....

14. Maiden name.....

Louise Shugar (?)

15. Birthplace.....

16. Informant.....

Home Records

Address.....

6403 Agate Rd. Hyattsville Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof.....

1-15-1951
(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

*Jan 15, 1951**19 51**Mr. Joe Berene*
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *1/15* 19 *51*, at *3:45* *A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 30 19 *50*, to *Jan 15* 19 *51*and that I last saw him alive on *Jan 15* 19 *51*Immediate cause of death *hemiplegia - base,*
mouth, intestinal tract

DURATION

2 mo

Due to.....

Cerebral palsy with
congenital blindness and cerebral

Due to.....

ageneria

Other conditions.....

*251X**87e*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Thomas A. Christensen MD

M. D. or other

Address.....

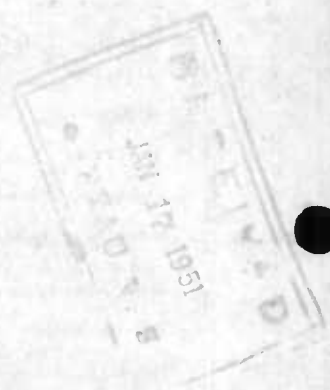
*College Park, Md*Date signed *Jan 15, 1951*

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

0897

232

1. PLACE OF DEATH COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Pr. Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Upper Marlboro		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Upper Marlboro, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) Rectory Lane	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Gervis (Middle) Gardner (Last) Shugart		(Month) 1 (Day) 18 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept 16, 1900
9. AGE last birthday 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of County Schools Education	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eugene Shugart		14. MOTHER'S MAIDEN NAME Margaret Gardner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT Mrs. Gervis Gardner Shugart		18. ADDRESS Rectory Lane, Upper Marlboro, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1 hour

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Secondary Anemia

1 year

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Atherosclerosis

3 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒

PLACE (Home, farm, factory, street, office bldg., etc.) **home**

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY? Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

None

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

James G. Harwood M.D. - Upper Marlboro, Md. - 1-18-51

Burial 1/20/51 Trinity Episcopal Upper Marlboro, Md.

Jan 19 1951 R. G. Smith Ritchie Brothers, Upper Marlboro, Md.

093688

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1808 243

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (Rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium		STREET ADDRESS (If rural, give location) 1241 25th St., N. W.	
3. NAME OF DECEASED (Type or Print) MARGARET E SMITH		4. DATE OF DEATH (Month) 1 (Day) 30 (Year) 1951	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 6/3/1923
9. AGE last birthday 27 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Louis Freeman Smith		14. MOTHER'S MAIDEN NAME Anna Daisey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-20-0021	
17. INFORMANT AND ADDRESS Decedent			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from Jan. 12, 1951, to Jan. 30, 1951, that I last saw the deceased

alive on Jan. 30, 1951, and that death occurred at 5:40 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Sanatorium

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

CARVER, MEMORIAL, FUNERAL SERVICE

784679

29 H ST. N. W. WASHINGTON D. C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH- COUNTY <u>Pr. George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Acokese</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Acokese</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Acokese</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>RELIA</u>	(First) (Middle) (Last) <u>SMITH</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 15 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 14 - 1908</u>
9. AGE last birthday <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Zebulon N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thompson Charles</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Plymal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year and dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>WA</u>	
17. INFORMANT AND ADDRESS <u>Bruce Smith</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>35</u> years
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral hemorrhage</u>	Antecedent cause(s) (b) <u>Tuber. Dorsalis</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>neurosyphilis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 47, 1947, to Jan. 15, 1951, that I last saw the deceased alive on Jan. 12, 1951, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

SIGNATURE <u>Alfred R. Lape, M.D.</u>	(Degree or title) <u>Chapman, Md.</u>	DATE SIGNED <u>1/15/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan 17 - 51</u>	NAME OF CEMETERY OR CREMATORY <u>Christ Episcopal</u>
LOCATION (City, town, or county) <u>Acokese Md.</u>	24. FUNERAL DIRECTOR <u>Smith & Son</u>	ADDRESS <u>Waco, Md.</u>
DATE REC'D BY LOCAL REGISTRARS SIGNATURE <u>Jan 16, 1951 M. H. Powers</u>		
Mrs. Alton Davis		

MARGIN RESERVED FOR BINDING

VS. A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. *245*

1. PLACE OF DEATH COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Pr. Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>5141 - Crittenden St</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Seland Memorial Hosp</i>		STREET ADDRESS (If rural, give location) <i>Hyattsville, Md</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Robert</i>	(Middle) <i>George</i>	(Last) <i>Solis</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>July 21, 1900</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>46</i> <i>mo</i>
11. FATHER'S NAME <i>Kenneth Dale Solis</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <i>Kenneth Solis - Father</i>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

924.0 Immediate cause (a) *Asphyxia*
 182 Antecedent cause(s) (b) *Suffocation*
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) <i>home</i>	(CITY OR TOWN) <i>Hyattsville - Pr. Geo. - Md.</i>	(COUNTY) <i>Pr. Georges</i>	(STATE) <i>Md.</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>1-29-51 A</i>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>bed - clothing suffocation in</i>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

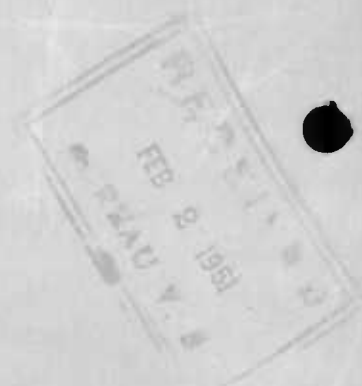
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0811 231

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Hill, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Hill, Md.</u>	
TOWN <u>Capitol Hill, Md.</u>		TOWN <u>Capitol Hill, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's Hosp.</u>		STREET ADDRESS (If rural, give location) <u>314 - 49th Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Clara</u> (First) <u>A</u> (Middle) <u>Jonas</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>January 19, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>78 70 ?</u>
9. AGE last birthday <u>75 3</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Albert Erkine Capital Hill Md</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardio-Vascular Renal Disease</u>	<u>10 years</u>	
Antecedent cause(s) (b) <u>131a</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 11, 1951, to Jan 19, 1951, that I last saw the deceased alive on Jan 19, 1951, and that death occurred at 9:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William Brannin MD 6124 Central Ave Capital Hill Md. 1/19/51

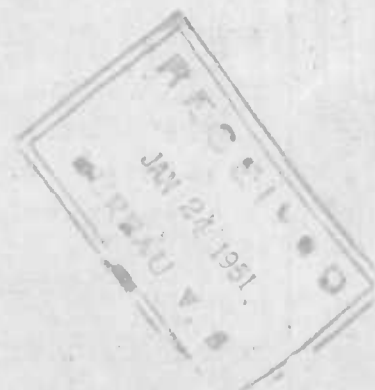
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1/24/51</u>	NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	LOCATION (City, town, or county) <u>Bladensburg Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1/23/51</u>	REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>F. Joseph some Hyattsville Md</u>	ADDRESS	

396906

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0812 245

1. PLACE OF DEATH- COUNTY Prince Georges Co. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Pr. Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) Hyattsville		CITY (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
TOWN Hyattsville		TOWN Hyattsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Home		STREET ADDRESS (If rural give location) Sacred Heart Home	
3. NAME OF DECEASED (Type or Print)	(First) Matilda	(Middle) B.	(Last) Spalding
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 6 Jan. 1857
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	9. AGE last birthday 94 yrs.
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Spaulding		14. MOTHER'S MAIDEN NAME Mary Rose Mudd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT Sacred Heart Home Records			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
452.0 Immediate cause (a) Congestive Heart failure		10 days
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerotic		2 yrs.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec. 28, 1950**, to **Jan. 25, 1951**; that I last saw the deceased alive on **Jan. 25, 1951**, and that death occurred at **1:10 p.m.**, from the causes and on the date stated above.

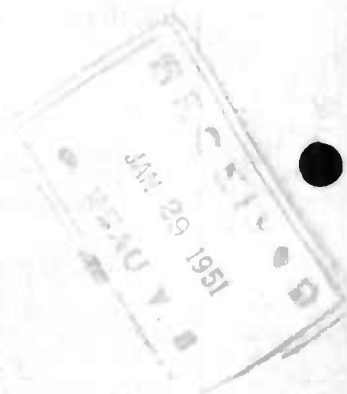
SIGNATURE *James F. Callin* (Degree or title) ADDRESS **322 H Street, N.E.** DATE SIGNED **1/26/51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 29 Jan. 1951	NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	LOCATION (City, town, or county) (State) Washington, D.C.
DATE REC'D BY LOCAL REG. Jan. 27, 1951	REGISTRAR'S SIGNATURE <i>James Severy</i>	24. FUNERAL DIRECTOR <i>James E. Ryan, Inc.</i>	ADDRESS 317 Pa. Ave. S.E.

781826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH - COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>D. C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>3146 Dunbarton Ave., N. W.</u>	
3. NAME OF DECEASED (Type or Print) <u>FRANCES</u>	(First) (Middle) (Last) <u>SWIENEY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1 2 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>8/14/1911</u>
9. AGE last birthday <u>39</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>	
11. BIRTHPLACE (State or foreign country) <u>No. Charlestown, N. H.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lloyd Hamlin</u>		14. MOTHER'S MAIDEN NAME <u>Ida Hutchins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/24, 1950, to 1/21, 1951, that I last saw the deceasedalive on 1/1, 1951, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Leo Pinucane M.D.Glenn Dale SanatoriumGlenn Dale, Md.1/1/51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1/1/51W. W. W. W.J. M. Lee & Sons Co. 303 4th St. N.E.220826 Washington D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0814

245

1. PLACE OF DEATH:

County Prince George
 City or town Hyattsville Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months
 Hospital, institution, or street address where death occurred:
Sacred Heart Home
 How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.
 City or town Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1346 Meridian Pl. N.W. Wash. D.C.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Betty H. Talburt

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband

George W. Talburt

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 14 1856

8. AGE:

94 Years11 Months23 Days

If less than one day

hrs.

min.

9. Birthplace

Kentucky

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Orville West

13. Birthplace

Kentucky

14. Maiden name

Mary Roy

15. Birthplace

Kentucky

16. Informant

Mrs. Mabel Talburt

Address

Quebec House Washington D.C.

17.

Burial

Date thereof

1-25-51

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Mt. Olivet Cemetery

Location

Bladensburg Rd. N.W. Wash. D.C.

18. Funeral director

The S. H. Hines Co.

Address

2901-14th St. N.W. Wash. D.C.

19.

Jan. 22, 1951Mrs. J. J. Severo

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 19 51 at 1:20 p21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 49 to Jan. 22, 51and that I last saw him alive on January 21 19 51

Immediate cause of death

Gastric hemorrhage
Cancer of stomach

DURATION

3 days
1 mo.

Due to

Due to

Other conditions

151x466 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

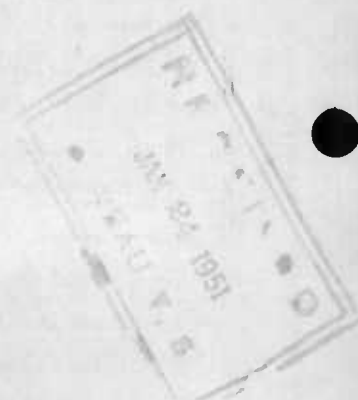
Injured at work?

23. SIGNATURE

Thomas J. Collins

M. D. or other

Address 322 H St., N.E. Date signed 1/22/51



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
 County Prince Georges
 City or town 7635 Waller Lane
 How long in above place of death? 13 yrs
 Hospital, institution, or street address where death occurred:
7635 Waller Lane
 How long in hospital or institution? (none) Washington 1900

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Washington
 Street No. 7635 Waller Lane
 (If rural, give LOCATION)

3. (a) FULL NAME

Carroll Lee Tavernier

3. (b) Social Security Number

578-07-5669

4. Sex M 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Catherine E. Tavernier
 8. (c) If alive, give age 38 years
 7. Birth date of deceased (mo., day, yr.) Aug 29 1907
 8. AGE: Years 43 Months — Days — If less than one day — hrs. — min. —

9. Birthplace Paris, Virginia
 (Town, county, and state)

10. Usual occupation Service Station Manager

11. Industry or business Shell Oil Co.

12. Name Eugene Murray Tavernier

13. Birthplace Virginia

14. Maiden name Jennie Ward Beemer

15. Birthplace Virginia (Clarke Co)

16. Informant Catherine E. Tavernier

Address 7635 Waller Lane - DC 19

17. Burial (Burial, cremation, or other) Burial Date thereof 8-19-51

Cemetery or crematorium Washington Natl.

Location Smithland, Md.

18. Funeral director M. W. Chambers Co.

Address 517-11 St SE WASH. D. C.

19. Date rec'd by registrar Jan 5 1951 Registrar Carrie F. Landell

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1951 at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1950 to Jan 4 1951

and that I last saw him alive on Jan 3 1951

Immediate cause of death Carcinoma of sigmoid with metastases

Due to 153X

Due to 462

Other conditions — none of note —

(Include pregnancy within 3 months of death)

Major findings of operations Same as above diagnosis replaced on 10/26/50 etc.

Date of op Aug 26 1950

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Natural Causes

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Carrie F. Landell M. D. or other

Address Washington 1950 Date signed Jan 4 1951

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 8 1951
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0816 242.

1. PLACE OF DEATH:

County Prince Georges
 City or town Forestville Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

7911 Marlboro Road S.E.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
 City or town Washington DC
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 7911 Marlboro Rd. S.E.
 (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME

Georgia Tayman

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Samuel O. Tayman
deceased

7. Birth date of deceased (mo., day, yr.) May 1 1863 6.(c) If alive, give age years

8. AGE: Years 87 Months 0 Days 0 If less than one day hrs. 0 min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Samuel B. Crawford

13. Birthplace

14. Maiden name Elizabeth Ryan

15. Birthplace

16. Informant Samuel O. Tayman
 Address 3807- Parkersburg Cathedral Rd

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan 15 1951
 (month) (day) (year)

Cemetery or crematory Edgar Hill
 Location Spittland Md.

18. Funeral director Thompson & Sons Co
 Address 390-4th St. N.E. Wash DC

19. Jan 12 1951 Edna F. Collier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12th 1951 at 3³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30th 1950 to Jan 12 1951
 and that I last saw him alive on Jan 11 1951

Immediate cause of death Cerebral Hemorrhage DURATION 6 days

Due to General Arterio Sclerosis

Left eye removed at Providence Hospital Nov 10 1950

Other conditions senile cataracts inclusion

331X (Include pregnancy within 3 months of death)
 Major findings of operations none other than noted
Balanced Date of op. Nov 1950

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Natural causes

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Phoebe Van Mattha M. D. or other

5480 Silver Hill Rd SE Date signed Jan 12 1951
 Address Washington DC



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0817 *mf5*

1. PLACE OF DEATH- COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia		COUNTY Page	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hyattsville Md		LENGTH OF STAY (in this place) 3 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Luray Va.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mother Jone's Rest Home				STREET ADDRESS --		(If rural give location)	
3. NAME OF DECEASED (Type or Print)		(First) Virginia		(Middle) Tharpe		(Last)	
5. SEX female		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower		8. DATE OF BIRTH 8/23/1863	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Luray Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Mann Spitler				14. MOTHER'S MAIDEN NAME Mary Strickler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Lester Tharpe		Hyattsville Maryland.	

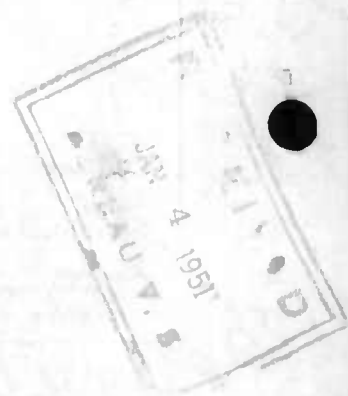
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
450.0 Immediate cause (a) <i>Semibity</i>					
Antecedent cause(s) (b) <i>Generalized Arteriosclerosis</i>					
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Dec*, 19*50*, to *Jan*, 19*51*, that I last saw the deceased alive on *Dec 30*, 19*50*, and that death occurred at *6:00 p.m.*, from the causes and on the date stated above.

SIGNATURE <i>Bernard A. Fitzgerald MD</i>		ADDRESS <i>802 Malcolm Dr. Sd. Md</i>		DATE SIGNED <i>1/2/51</i>	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE <i>1/4/1951</i>		NAME OF CEMETERY OR CREMATORY <i>Luray Cemetery</i>	
LOCATION (City, town, or county) <i>Luray Va.</i>		(State) <i>VA</i>			
DATE REC'D BY LOCAL REG. <i>Jan 3, 1951</i>		REGISTRAR'S SIGNATURE <i>James Severy</i>		24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>	
				ADDRESS <i>Hyattsville Maryland.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0818 232

1. PLACE OF DEATH:

County Prince GeorgesCity or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

Rectory Lane, Upper Marlboro, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)Street No. Rectory Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Gilberta Irene Tippet

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

P. Frank Tippet

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2/5/76

8. AGE:

Years

Months

Days

If less than one day

74

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Domestic

FATHER

12. Name

Samuel G. Townshend

13. Birthplace

Maryland

MOTHER

14. Maiden name

Sarah Angellia Pyles

15. Birthplace

Maryland

16. Informant

Mrs. John Garner

Address

Upper Marlboro, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

1 28 51
(month) (day) (year)

Cemetery or crematory

Cheltenham Methodist

Location

Cheltenham, Maryland

18. Funeral director

Ritchie Brothers

Address

Upper Marlboro, Maryland.

19.

(Date rec'd by registrar)

Jan 27 1951R. E. Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 25 1951 at 9:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 26 1951 to Jan 25 1951and that I last saw her alive on Jan 25 1951

Immediate cause of death

Cerebral Hemorrhage

DURATION

140

Due to

general arterio-sclerosis

Due to

B31x

Other conditions

83a Paget disease of bone

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide natural Cause of Canine

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. E. Smith

M. D.

Address

Washington 1900

Date signed

Jan 26 1951

MARGIN RESERVED FOR BINDING

9-43-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
JUN 20 1951
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH - COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>E. Riverdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Gen. Hosp</u>		STREET ADDRESS (If rural, give location) <u>5421 - 55th Pl.</u>	
3. NAME OF DECEASED (Type or Print) <u>Edna MARY TRABAND</u>	4. DATE OF DEATH <u>JAN 1 1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>10 Sept 1885</u>
9. AGE last birthday <u>65</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House Wife</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>John R. Beale</u>	14. MOTHER'S MAIDEN NAME <u>EMMA J. Beale</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Harold W. Ireland (6612 Locust St. Riverdale)</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause

(a) Multiple pulmonary emboli, bilateral

46.9 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive - arteriosclerotic heart disease with

(c) Congestive Heart Failure

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Carcinoma of Gall Bladder & metastases to liver

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1, 1950, to Jan 1, 1951, that I last saw the deceased

alive on Jan 1, 1951, and that death occurred at 11:50 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

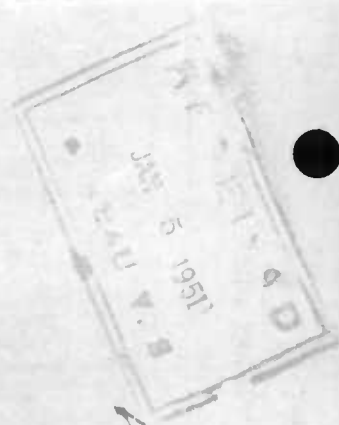
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 248

0820 251

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
TOWN <u>Chesley</u>		TOWN <u>Brandywine</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Freemasons Hospital</u>		STREET ADDRESS <u>-</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Amrose</u> (Middle) <u>Treacle</u> (Last)		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 27 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>30</u> yrs. If under 1 year Months. If under 24 hrs. Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Arnold Treacle</u>		14. MOTHER'S MAIDEN NAME <u>Clara Smart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Arnold Treacle Brandywine Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
1756.2 Immediate cause (a) <u>Toxemia & Malnutrition</u>		
122b Antecedent cause(s) (b) <u>Intestinal Obstruction</u>		
(c) <u>Congenital Abnormal Enlarged Colon</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>19 Jan 51</u>	19b. MAJOR FINDINGS OF OPERATION <u>See 18-IC</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 Dec., 1950, to 26 Jan., 1951, that I last saw the deceased alive on 26 Dec., 1951, and that death occurred at 12 30 m., from the causes and on the date stated above.

SIGNATURE <u>Robert B. Sauer</u>		ADDRESS <u>Upper Marlboro Md</u>		DATE SIGNED <u>26 Jan 51</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE <u>1/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>St Johns</u>	LOCATION (City, town, or county) <u>Chesley Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>1-27-51</u>	REGISTRAR'S SIGNATURE <u>Robert B. Sauer</u>	24. FUNERAL DIRECTOR <u>Wm. H. Sauer & Son</u>		
ADDRESS <u>Chesley Md</u>				

2-1-1-27-0253-40-2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
TOWN <u>Glenn Dale (Rural)</u>		TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>741- 2'd St., N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>RAYMOND</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>JANY. 5th</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1/16/16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer, construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>34</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Halifax, N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Wade</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>lost</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

7 months 11 days

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-19-1950, to 1-5-1951, that I last saw the deceasedalive on 1-4-1951, and that death occurred at 12:05 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Leo PenecaneM.D.Glenn Dale Sanatorium,Glenn Dale, Maryland1/5/51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 1/5/51

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

W. E. WernEver Memorial Funeral 29-H St NW970246Carol McKenney Edward S. 34

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. *245*

1. PLACE OF DEATH- COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Prince Georges</i> County	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>West Hyattsville Md</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>West Hyattsville Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>2709 Kirkwood Place</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Gladys</i> (Middle) <i>Glendolyn</i> (Last) <i>Ward</i>		(Month) <i>Jan</i> (Day) <i>8</i> (Year) <i>1951</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>April 10, 1904</i>
9. AGE last birthday <i>46 years</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>	
11. BIRTHPLACE (State or foreign country) <i>Groveland Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>William Harvey Talcott</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Spore</i>	
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Calvert O Ward W. Hyattsville Md.</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
442x Immediate cause (a) <i>Cerebral Compression</i>	
Antecedent cause(s) (b) <i>Intracranial hemorrhage</i>	
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Cardiovascular renal disease</i>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <i>John J. Maloney M.D. Dep. Med. Exam - Chevy Chase - Hyattsville Md.</i>	DATE SIGNED
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Jan 12, 1951</i>
NAME OF CEMETERY OR CREMATORY <i>Geo Washington</i>	LOCATION (City, town, or county) (State) <i>Hyattsville Md</i>
DATE REC'D BY LOCAL REG. <i>Jan 11, 1951</i>	REGISTRAR'S SIGNATURE <i>James Sevey</i>
24. FUNERAL DIRECTOR <i>F. Gaschi Sons</i>	ADDRESS <i>Hyattsville Md.</i>

310 386

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *245*

1. PLACE OF DEATH COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>md</i> COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Oak springs md</i>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>4816-Blackfoot Rd</i>		STREET ADDRESS (If rural, give location) <i>4816 Blackfoot Rd</i>	
3. NAME OF DECEASED (Type or Print) <i>Eugene</i> (First) <i>Reed</i> (Middle) <i>WILTBANK</i> (Last)		4. DATE OF DEATH (Month) <i>JAN</i> (Day) <i>1</i> (Year) <i>1951</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>12/18/1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>lumber dealer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>lumber</i>	9. AGE last birthday <i>70</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTH PLACE (State or foreign country) <i>Atlantic City N.J.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Peter White</i>		14. MOTHER'S MAIDEN NAME <i>Emma L. McKinnis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No. <i>5-78-09-449</i>	
17. INFORMANT <i>Nancy E. Wilthank College Park md</i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
(a) <i>420.0 Immediate cause</i>		<i>CORONARY THROMBOSIS</i>	<i>THX</i>
(b) <i>61 Antecedent cause(s)</i>		<i>ARTERIOSCLEROTIC HEART DISEASE</i>	<i>10-15 YR</i>
(c) <i>11. OTHER SIGNIFICANT CONDITIONS</i>		<i>DIABETES Mellitus</i>	<i>1 1/2 YR</i>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
HOMICIDE	INJURY		(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Oct 48*, 19*50*, to *Nov 50*, 19*50*, that I last saw the deceased alive on *4 Nov 50*, and that death occurred at *1 30 P* m., from the causes and on the date stated above.

SIGNATURE *Ed. Etienne M.D.* (Degree or title) ADDRESS *College Park, Md* DATE SIGNED *1-1-51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>1/4/51</i>	<i>Forest Cemetery</i>	<i>St Michaels</i>	<i>md</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>Jan 3 1951</i>	<i>James Severy</i>	<i>F. Gasche</i>	<i>southern Hyattsville md</i>	

290687

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *275*

1. PLACE OF DEATH COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Prince George</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>	
TOWN <i>Hyattsville</i>		TOWN <i>Beltsville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mother Jones Rest Home</i>		STREET ADDRESS (If rural, give location) <i>None</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Christina</i>	(Middle) <i>(NMN)</i>	(Last) <i>Wissman</i>
4. DATE OF DEATH	(Month) <i>Jan.</i>	(Day) <i>21</i>	(Year) <i>1951</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Sept. 7, 1865</i>
9. AGE last birthday <i>85</i> yrs.	If under 1 year Months <i></i> Days <i></i>	If under 24 hrs. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife - Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>Beltsville, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Jacob Feighenne</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Benson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY No. <i>None</i>	17. INFORMANT <i>Mr. Henry J. Wissman</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
443x Immediate cause	(a) <i>Hypertension, Heart Disease</i>	<i>?</i>
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <i>Hypertension, Myocardial</i>	<i>?</i>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8/4*, 19*50*, to *1/21*, 19*51*, that I last saw the deceased alive on *1/21*, 19*51*, and that death occurred at *11:00* m., from the causes and on the date stated above.

SIGNATURE *Dr. J. J. Smith* (Degree or title) ADDRESS *314 Oak an Lane* DATE SIGNED

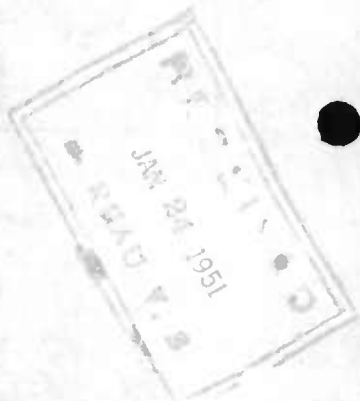
23. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>	DATE THEREOF <i>Jan. 25, 1951</i>	NAME OF CEMETERY OR CREMATORY <i>St John's Episcopal Cemetery</i>	LOCATION (City, town, or county) (State) <i>Beltsville Maryland</i>
DATE REC'D BY LOCAL REG. <i>Jan 22 1951</i>	REGISTRAR'S SIGNATURE <i>J. J. Smith</i>	24. FUNERAL DIRECTOR <i>W.W. Chambers Co.</i>	ADDRESS <i>5801 Cleve. Ave Riverdale, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

411

Lawrence Ave



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D. C.</u> COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>1119 23rd St., N. W.</u>	
3. NAME OF DECEASED (First) <u>Catherine</u> (Middle) <u>WOODLAND</u> (Last) <u>WOODLAND</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>5/15/1920</u>
9. AGE last birthday <u>30</u> yrs.		10. If under 1 year Months <u>---</u> Days <u>---</u> Hours <u>---</u> Mins. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus girl</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Annex Gov't Cafeteria Services</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur Pinkett</u>		14. MOTHER'S MAIDEN NAME <u>Alice Pinkett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>577-30-8050</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr 19, 1949, to 1. 13, 1951, that I last saw the deceased

alive on 1. 13, 1951, and that death occurred at 2:57 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Sanatorium

DATE SIGNED

Glenn Dale, Maryland

1/13/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/13/51</u>	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) <u>Washington D.C.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/14/51</u>	REGISTRAR'S SIGNATURE <u>Joe Weiss</u>	24. FUNERAL DIRECTOR <u>Joe Janifer</u>	ADDRESS <u>1141-22 St. NW.</u>	

790679

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

